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# Parent-Young Adult Conversations about Mental Health

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# Parent-Young Adult Conversations about Mental Health

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# Abstract

## Parent-Young Adult Conversations about Mental Health

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Despite the importance of mental health and the prevalence of mental illness, these health topics remain some of the most stigmatized in America. Stigma related to mental health and mental illness is often perpetuated through family communication, and research has suggested that parent-child communication, in particular, is a primary source of information and socialization for younger family members. However, it is often the *quality* of parent-child communication, rather than the *quantity* of communication, that influences important relational and individual outcomes. In this study, a multiple goals theoretical perspective was used to explore the quality of parent-young adult child (YA) communication about mental health by investigating how attention to relevant interaction goals may predict more or less favorable outcomes, such as relational distancing and mental health help-seeking attitudes. In order to examine the role of stigma in attending to interaction goals during mental health conversations, the model of stigma communication also was used as a guide. Members of 39 parent-YA dyads ($N$ = 78) engaged in a conversational task in which they were prompted to discuss mental health and related topics. Following this conversation, participants individually completed an online questionnaire asking them to reflect on their mental health conversation and to

report on their perceptions of attention to interaction goals and relevant outcomes. Results demonstrated that parent and YA perceptions of attention to interaction goals and the use of stigma communication predicted more and less favorable outcomes for both parents and YAs. Most notably, perceptions of greater attention to the goal of avoidance consistently yielded undesirable outcomes. Additionally, findings indicated that perceptions of greater use of stigma communication may constrain attention to the interaction goals of affirming positive face, affirming negative face, and engaging with mental health topics. Theoretical contributions to the multiple goals framework are presented, and practical implications related to improving the quality of parent-YA communication about mental health are offered.

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# Chapter 1: Introduction

Each year, 43.8 million Americans over age 17 experience mental health concerns, and nearly 75 percent of all lifetime cases of mental illness emerge before age 24 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Mental illness, which encompasses a wide range of health conditions "involving changes in thinking, emotion, or behavior," is associated with "distress and problems functioning" in social, familial, and occupational settings (American Psychiatric Association [APA], 2015). Together, mental illnesses are more common than cancer and diabetes and are a leading cause of disability in the United States (National Institutes of Mental Health [NIMH], 2017). Along with chronic mental illness, individuals can also experience acute mental health concerns. Young adults (YAs), in particular, may experience anxiety or depressive symptoms that accompany the new academic, social, and financial demands of young adulthood (Dusselier, Dunn, Wang, Shelley, & Whalen, 2005; SAMHSA, 2015). Introducing these demands, for example, may interfere with YAs' mental health, which includes "emotional, psychological, and social well-being" and "affects how [people] think, feel, and act" (mentalhealth.gov, 2017). In fact, one in 10 YAs experiences a period of depression over the course of this transitional life stage (mentalhealth.gov, 2017). However, despite the importance of mental health and the prevalence of mental illness, these health topics remain some of the most stigmatized in America (Phelan, Link, Stueve, & Pescosolido, 2000; World Health Organization [WHO], 2017).

The stigma surrounding mental health and mental illness has been identified as one of the major barriers to psychological help seeking and treatment adherence, particularly for YAs (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, 2004; Dennis & Chung-Lee, 2006; Eisenberg, Downs, Golberstein, & Zivin, 2009). Whether their distress is acute or chronic, individuals experiencing mental health concerns often struggle to seek mental health care or utilize mental health services. Overall, 59 percent of individuals with mental health concerns do not use mental health services (SAMHSA, 2015). This disparity often results in negative health,

relational, and work-related outcomes (Kessler et al., 2001; Kessler, Walters, & Forthofer, 1998). Although decades of research have demonstrated the efficacy of mental health treatments (e.g., psychotherapy, cognitive behavioral therapy, medication) in reducing symptoms and improving functioning across mental health conditions, social and systemic obstacles to these services still exist (Chorpita et al., 2011; Elkin et al., 1989; Shedler, 2010; Smith, Glass, & Miller, 1980; Wampold, 2001). While stigma is not the only barrier to utilizing mental-health services, it is a major impediment to clinical and non-clinical help seeking (Corrigan, 2004; Dennis & Chung-Lee, 2006; Eisenberg et al., 2009).

Mental health and mental illness stigma is often perpetuated through family communication, and research suggests that stigmatizing messages about mental health from family members are associated with less positive clinical help-seeking attitudes than are messages that do not stigmatize mental health (Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018). Parent-child communication, in particular, is a primary source of information and socialization for younger family members; therefore, exploring parent-YA communication about mental health is essential. The quality of these conversations may shape both parent and YA help-seeking attitudes and stigma-related beliefs associated with mental health and mental illness (Dailey, Thompson, & Romo, 2014; Medved, Brogan, McClanahan, Morris, & Shepherd, 2006; Miller-Day, 2008; Vangelisti, Crumley, & Baker, 1999).

Communication researchers interested in exploring stigmatized health topics have primarily focused on HIV/AIDS, certain types of cancer, and weight management (e.g., obesity, type II diabetes) contexts. Although some communication scholars (e.g., Arroyo & Segrin, 2013; Bauer, 2011; Flood-Grady, 2016; Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018; Imai & Dailey, 2016; Scott, Caughlin, Donovan-Kicken, & Mikucki-Enyart, 2013; Segrin, 2001, 2013) have investigated stigma and communication related to mental health and mental illness, this remains an underexplored health context in the field of interpersonal communication. Stigmatized health topics often share overlapping features such as uncertainty and risk; however,

mental health and mental illness contexts are comprised of distinct characteristics that warrant further exploration.

For instance, mental illness may be caused by a combination of biological factors such as genetic predisposition, family history, brain chemistry, and/or environmental factors including trauma and abuse (Mayo Clinic, 2015). Psychological distress can be both chronic and acute, both visible and invisible (Mayo Clinic, 2015; Pachankis, 2007). Mental health concerns are often accompanied by psychosocial challenges, and individuals with mental illnesses are at greater risk for experiencing comorbitities such as chronic stress, diabetes, cardiovascular disease, and pulmonary disease (Goodell, Druss, Walker, & Mat, 2011; Goodwin, Davidson, & Keyes, 2008; Kronick, Bella, & Gilmer, 2009; Link & Phelan, 2006; Strine et al., 2008). Additionally, some mental illnesses (e.g., major depression and schizophrenia) are associated with danger, incompetence, and social rejection for individuals with the condition and others connected to that person (Corrigan & Miller, 2004; Pescosolido et al., 2010; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). Futhermore, maintenance of mental health and management or treatment of mental illness is often accompanied by financial strain and additional stigma (Corrigan, 2004; Eisenberg et al., 2009; Golberstein, Eisenberg, & Gollust, 2008). Thus, mental health provides a nuanced and complex context for further investigating communication about stigmatized health information.

Segrin (2013) suggests that family interaction patterns play a role in the "cause, course, and treatment of mental health problems;" however, to our knowledge the quality of conversations that family members have about mental health and mental illness primarily remain unknown (p. 512; for exception see Flood-Grady & Koenig Kellas, 2018). Research indicates that the *quality* of parent-YA/adult child talk, rather than just the *quantity* of talk, often impacts important individual and relational outcomes (e.g., Donovan, Thompson, LeFebvre, & Tollison, 2017; Miller-Day, 2002; Miller-Day & Kam, 2010; Scott, 2010). Examining the quality of parent-YA mental health conversations through communicators' attention to relevant interaction goals can help extend understanding of what makes better and worse communication about this

stigmatized health topic, including the role of stigma in these conversations. Existing research suggests that different types of talk about mental health and mental illness perpetuate stigma and are associated with more and less positive help-seeking attitudes, perceptions of relational closeness between communicators, and conversation satisfaction (Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018). As such, understanding what constitutes higher and lower quality parent-YA conversations about mental health is crucial.

The purpose of this study, then, is to explore the quality of parent-YA communication about mental health through attention to various interaction goals during conversations about mental health and to examine associations among variations in effective goal attention and relevant individual, relational, and health-related outcomes including relational closeness and help-seeking attitudes. Given the prevalence of mental health concerns as well as the interdependent influence of parents and YAs on one another's health behaviors, exploring parent-YA talk about mental health and mental illness is imperative to reducing the disparity between the number of individuals experiencing psychological concerns and the number seeking and receiving mental health services (Dailey et al., 2013; Eisenberg et al., 2009).

Two theoretical frameworks guide this exploration—a multiple goals perspective (Caughlin, 2010; Goldsmith, 2001, 2004; O'Keefe, 1988) and Smith's (2007, 2011) model of stigma communication (MSC). Together, these theoretical approaches provide a lens through which to evaluate effective attention to interaction goals (i.e., task, identity, and relational goals) and understand the role of stigma in attending to interaction goals during parent-YA conversations about mental health. Evidence suggests that effectively attending to relevant interaction goals is, for example, associated with perceptions of communicators' effectiveness, helpfulness, conversation satisfaction, and relational closeness (Caughlin, 2010; Goldsmith, Lindholm, & Bute, 2006; O'Keefe & McCornack, 1987; O'Keefe & Shepherd, 1987; Scott & Caughlin, 2012). Therefore, exploring parent and YA attention to relevant interaction goals during conversations about mental health is useful in assessing communication quality. Additionally, this study emphasizes the dyadic nature of conversations, and as such, examines

the perspectives of parents *and* YAs with respect to this stigmatized health context. Rather than using hypothetical scenarios, only online questionnaires, or interviewing one member of a dyad, conversations between family members were elicited to help parents and YAs engage with the topic as well as to help make salient the interaction goals addressed in the post-conversation questionnaire. Together, this design aimed to extend scholarly understanding of parent-YA communication about mental health and stigmatized health topics in general.

Following this brief introduction, Chapter Two reviews existing literature related to difficult conversations, parent-child communication, and stigmatized health topics. A rationale and theoretical framework for the proposed study, along with hypotheses, are also presented in Chapter Two. Chapter Three outlines the methodology of the present study, including study design, procedures, and instruments used to measure variables of interest. Chapter Three also describes data analysis plans for the current project. In Chapter Four, results are presented and summarized. Lastly, Chapter Five discusses findings, contributions, and limitations of this investigation.

## Chapter 2: Literature Review and Rationale

With the prevalence of mental illness, particularly during young adulthood, as well as the low uptake of mental health services in the United States, it is critical that parents and YAs engage in high quality communication about mental health for a number of reasons (Corrigan & Miller, 2004; NIMH, 2017; Petronio, 1999; SAMHASA, 2016). First, families socialize and educate their members on a number of topics, including health-related and stigmatized issues (Brody, Flor, Hollett-Wright, & McCoy, 1998; Koenig Kellas, 2010; Miller-Day, 2011; Segrin, 2001). Through their interactions, families establish norms about which health-related topics are appropriate to discuss and in which health behaviors it is appropriate to engage (Ormondroyd et al., 2008). Thus, families are especially influential in their members' health beliefs and behaviors. Secondly, parents, in particular, are a primary source of influence on children's health-related behaviors (Koenig Kellas, 2010). Mothers, even more so than fathers, have been found to play an integral role in overall family healthcare (Noller & Callan, 1990). Specifically, mothers' health attitudes and behaviors have been found to explain their children's use of health services, and some research suggests that adolescents also exert influence on their mothers' health behaviors, including dieting and exercising (Aday & Eichhorn, 1972; Dailey et al., 2014). Lastly, parent-YA communication about mental health may include themes, content, and ideologies that differ from communication with friends, acquaintances, healthcare providers, and media sources about such stigmatized topics (Koenig Kellas, 2010; Medved et al., 2006). Therefore, if a father, for instance, mocks or criticizes people who use medication to treat depression, the other family members who witness this criticism may adopt the belief that taking medication for depression is not acceptable. They may even begin to believe that it is unacceptable to talk about depression or medication within their family and beyond.

Although existing research has explored family and parent-child communication about taboo or stigmatized topics including sexuality, mental illness, and substance use, few studies have explored talk about mental health within family or parent-YA contexts (e.g., Arroyo & Segrin, 2013; Flood-Grady, 2016; Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018;

Kirkman, Rosenthal, & Feldman, 2005; Miller-Day & Fisher, 2008; Segrin, 2001). Findings from studies emphasizing family communication and mental health indicate that family communication patterns, particularly the interaction patterns of parents and children, are related to mental health conditions including disordered eating, social anxiety, depression, and schizophrenia (Arroyo & Segrin, 2013; Miller-Day & Fisher, 2008; Segrin, 2001). This research also suggests that parents are the primary familial sources of mental health messages for YAs and that they share mental health narratives with YAs that highlight struggle and caution along with lessons of mental illness awareness and understanding (Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018). While research highlights that some parents and YAs are communicating about mental health topics, they also may avoid talking about mental health and mental illness in order to avoid stigma, protect private information, or due to a lack of confidence in their abilities to discuss these complex topics (Choi et al., 2016; Venetis, Chernichky-Karcher, & Gettings, 2017). Nevertheless, given the ubiquity of mental health concerns and the impact of parents and children on one another's health beliefs and behaviors, it is important to assess the quality of parent-YA conversations about mental health, as communication about stigmatized health topics has implications for relationships, individuals, and their health.

## CHALLENGES OF TALKING ABOUT STIGMATIZED HEALTH INFORMATION

### Difficult Conversations

Communicating about stigmatized health topics, such as mental health and mental illness, can be difficult for many reasons. Not only can these conversations include complex medical information related to prevention, detection, and treatment of mental illness, but talking about stigmatized health information can also present connected and conflicting goals or concerns that may threaten communicators' identities and relationships (Caughlin, 2010; Caughlin et al., 2009; Goldsmith, 2001, 2004; O'Keefe & Shepherd, 1987; Scott et al., 2013). For example, if Dev says, "There's absolutely no way mental illness is hereditary. That's just idiotic," during a conversation with his father, his dad's identity as a person who feels knowledgeable about the

genetic factors of mental illness may be threatened. In turn, if Dev's dad then tells Dev what he has learned from studying mental illness and genetics, Dev's own identity as someone who wants his thoughts and beliefs to be valued may be threatened. As interactions become more challenging, a variety of interaction goals becomes increasingly relevant (O'Keefe, 1988). Together, these aspects of talking about stigmatized health information can result in difficult or complicated communicative situations (Goldsmith, 2001, 2004; O'Keefe & Delia, 1982; O'Keefe, 1988; Wilson, 2002).

Difficult conversations, such as those about stigmatized health information, are characterized by unwelcome topics, ambiguity, and strong emotions (Donovan, 2015). These qualities can make it challenging for individuals to begin, continue, or resolve conversations in satisfying ways. Of course, not all individuals find discussing highly stigmatized information like mental health and mental illness difficult. However, the uncertainty and complexity surrounding these issues parallels other stigmatized health topics including sex, substance use, HIV/AIDS, and some cancers, which research suggests are often difficult to discuss (Caughlin et al., 2008, 2009; Donovan-Kicken & Caughlin, 2010; Edwards, Donovan-Kicken, & Reis, 2014; Kosenko, 2010; Miller-Day, 2002; Phelan et al., 2000; Scott et al., 2013; WHO, 2017). While such subjects may be considered taboo on either societal or relational levels, if even one individual in an interaction perceives mental health as an awkward, off-limits, or confusing topic, conversational difficulty likely follows (Baxter & Wilmot, 1985; Donovan, 2015).

Further complicating the already challenging task of discussing sensitive health information with another person, conversations about stigmatized health information also are accompanied by several, often competing or conflicting goals (Clark & Delia, 1979; Goldsmith, 2001, 2004). The presence of competing demands and efforts to accomplish these various goals constitutes complex communicative situations (O'Keefe & Delia, 1982; Goldsmith, 2001, 2004; Wilson, 2002). For example, a mother may want to be honest in a conversation about her own mental health history, but also she may want to ensure that her YA son does not unduly worry about or fear what a family history of mental illness means for his own health (Caughlin et al.,

2009). In order for the mother to successfully, sensitively, and appropriately achieve the competing goals of being honest while also avoiding scaring her son, she needs to communicatively attend to the relevant interaction goals that are salient to this conversation (Clark & Delia, 1979; Goldsmith, 2001; Goldsmith, McDermott, & Alexander, 2000).

Clark and Delia (1979) outlined three overarching interaction goals—task (or instrumental) goals, identity goals, and relational goals. *Task goals* refer to the communication objective that defines the interaction (e.g., to ask, to persuade, to disclose; Clark & Delia, 1979). For example, when Mary, a YA, asks her father for help managing her obsessive-compulsive disorder (OCD), her task goal is to seek support. *Identity goals* refer to communicators' self-presentation and mutual reinforcement of self and others' public images in interactions (Brown & Levinson, 1987; Goffman, 1967; Goldsmith, 1992). Coupled with Mary's efforts to seek support from her father, she also may want to express that she will remain independent and autonomous in other areas of her life despite needing some extra help managing her OCD. Lastly, *relational goals* emphasize the communicators' relationship and the desire to establish, maintain, or change that relationship. Taking Mary's situation one step further, she also may want to assure her father that his help will not alter their current relational dynamics, for instance, she would still like to continue their weekly tennis game.

Depending on the situation, some interaction goals will be more relevant to the conversation than will others (Goldsmith, 2001, 2004). For instance, in a high stress or emergency situation, it is likely more pertinent for Mary to focus on the task goal of seeking support for her OCD rather than ensuring that her father continues to perceive her as independent (Brown & Levinson, 1987; Clark & Delia, 1979; Goldsmith, 2001; O'Keefe, 1988). Thus, identity goals, for example, may become less of a priority in the conversation, constraining Mary's ability to fully accomplish both task and identity goals (Caughlin, 2010; Donovan-Kicken, Guinn, Romo, & Ciceraro, 2013; O'Keefe & Shepherd, 1987; Wilson, 2002).

## Parent-YA Relationships

Attending to the complex and often competing task, relational, and identity goals present in conversations about stigmatized health topics may be made more difficult by the shifting relational dynamics of parent-child relationships as children transition out of adolescence and enter young adulthood (Arnett, 1998, 2001, 2004; Flood-Grady & Koening Kellas, 2018; Goldsmith, 2001, 2004). For YAs (i.e., ages 18 to 24), young adulthood is often characterized by increased autonomy, decreased supervision, living among peers, and increased social, occupational, and financial responsibility (Arnett, 1998, 2004; Dusselier et al., 2005). Geographic relocation is also common among YAs as they transition into college and careers (Arnett, 2001, 2004; Dubas & Petersen, 1996). During this time, YAs often establish their own interests, beliefs, attitudes, and lifestyles that may diverge from those of their parents (Arnett, 2004). These differences in values also can make it difficult for parents and YAs to discuss sensitive topics out of fear of discomfort or conflict (Donovan, 2015). Along with this, parents must cope with YA attempts to renegotiate the parent-child relationship into peer-like or equal relationships between adults (Arnett, 1998, 2001). Some parents also experience stress or negative emotions when YAs move out of the house, a transition often characterized by unpredictability and uncertainty for parents (Mitchell & Wister, 2015). Despite YAs' physical distance and increased independence, research suggests they want to remain connected to their parents (Holland & O'Neill, 2006).

Just as the parent-YA relationship changes, how and what parents and YAs talk about may also change (Arnett, 2004; Donovan et al., 2017; Golish & Caughlin, 2002). Previous research suggests some parents disclose to YA children in a more peer-like manner (i.e., "being real") as opposed to one rooted in a typical parent-child dynamic (Donovan et al., 2017, p. 185). Parents also may be willing to discuss more and different types of information with YAs since they are better able to process complicated information than are younger children (McManus & Nussbaum, 2013). Thus, parents and YAs may be discussing topics such as illness, substance use, sex, and mental health (Crook & Dailey, 2017; Donovan et al., 2017; Flood-Grady &

Koening Kellas, 2018; Greenwell, 2018; Rotheram-Borus, Draimin, Reid, & Murphy, 1997). That said, research also suggests YAs are skilled at avoiding topics and keeping information from their parents (Golish & Caughlin, 2002).

Therefore, parents and YAs may grapple with whether or not to discuss sensitive, personal, or stigmatized information with one another (e.g., Caughlin & Petronio, 2004; Venetis et al., 2017). Managing the decision to initiate, disclose, maintain privacy, ask for help, or offer support (or not) adds complexity to difficult conversations and can present dilemmas for communicators (Bos, Kanner, Muris, Janssen, & Mayer, 2009; Chaudoir & Fisher, 2010; Donovan et al., 2017; Goldsmith & Fitch, 1997; Goldsmith et al., 2006; Venetis et al., 2017). During parent-YA conversations about mental health, communicators may encounter dilemmas such as balancing privacy concerns with the desire to be honest or to seek support (Goldsmith & Fitch, 1997; Petronio & Venetis, 2017). A YA son, for example, may want to inform his mother about his schizophrenia diagnosis, but he also may worry about his mother telling others about this private health matter. Revealing and concealing stigmatized health information within families can be beneficial (e.g., can facilitate coping) as well as detrimental (e.g., could perpetuate stigmatization), further complicating such conversations (Caughlin & Petronio, 2004; Petronio, 2017).

Similarly, parents and YAs may attempt to manage the desire for advice with the desire to maintain autonomy or the desire for openness with topic avoidance (Brown & Levinson, 1987; Donovan et al., 2017; Goldsmith & Fitch, 1997; Golish & Caughlin, 2002; Guerrero & Afifi, 1995). During difficult conversations or complex communicative situations, parents and YAs may try to maintain their renegotiated parent-child relationship (i.e., relating as equals) with the need for support. Depending on the ways these varied and often-conflicting interaction goals are addressed, parent and YA roles could shift or new roles could be created (Goldsmith et al., 2006). For instance, returning to Mary, her relationship with her father could shift from a peer-like relationship into more of a patient-caregiver relationship if she does not communicate the type and level of support she desires from him. If Mary does not in some way express her need

to remain autonomous when she asks for her father's added help, he may end up acting as her caregiver, rather than as her equal.

## THEORETICAL FRAMEWORK

### Multiple Goals Theoretical Perspective

One useful way of exploring the complex and at times conflicting or constraining goals present during interactions about stigmatized health topics is through a Multiple Goals Theoretical Perspective (Caughlin, 2010; Clark & Delia, 1979; Goldsmith, 2004; O'Keefe, 1988; O'Keefe & Shepherd, 1987; Wilson, 2002). This approach encompasses numerous goal-focused theories including O'Keefe's (1988) Message Design Logics, Goldsmith's (2001, 2004) Rhetorical/Normative Approach, and Dillard's (1990) Goals-Plans-Action model. Overall, this perspective posits that communication is a purposeful, goal-driven process. Rather than simply exchanging information through communicative efforts, individuals often communicate to accomplish multiple interaction goals (Clark & Delia, 1979; O'Keefe, 1988; Wilson, 2002).

By using a multiple goals approach, scholars can assess communicators' attention to task, identity, and relational goals that are relevant to a given situation, since depending on the circumstances of the interaction, some interaction goals will be more normatively relevant than will others (Goldsmith, 2001, 2004; O'Keefe, 1988). Normatively relevant goals are those that are conventionally expected or inherently understood to be germane to certain communicative situations and social contexts. Normatively relevant interaction goals align with or are rooted in the social conventions of a specific situation and relationship (Goldsmith, 2004; O'Keefe, 1988). For example, in support-seeking contexts within close relationships, it is conventional for the person who is being asked to provide support to comply and support the support seeker (Goldsmith, 2004). At the same time, such support-seeking attempts may also threaten the support provider's autonomy (i.e., providing support is inherently a burden on time and energy), and thus it is often normatively relevant to thank the supporter for their help (Goldsmith, 2004; Goldsmith & Fitch, 1997).

Not only does this example illustrate interaction goals that are normatively relevant, but it also demonstrates that as situations become more complex, the goals relevant to the situation increase and often compete, constrain, or conflict with one another, making goal achievement difficult (Goldsmith, 2001; O'Keefe & Delia, 1982). Thus, along with considering the normative context of more and less salient interaction goals, it is important to consider the ways that incongruent task, identity, and relational goals add yet another layer of complexity to already challenging communication situations (e.g., Goldsmith & Fitch, 1997). Dilemmas may emerge as a result of these competing goals. For instance, a parent may want to offer a YA advice about where to seek mental health care, but this advice-giving moment may call into question the YA's competence and impede upon the YA's independence (i.e., threaten YA's identity). This may make the parent seem intrusive, but on the other hand, a parent who offers no suggestions may seem unconcerned (Goldsmith & Fitch, 1997). There are discursive ways to minimize the potential that such dilemmas will arise; however, when identity goals are prioritized, for example, attention to relational and task goals can become constrained, buried in the interaction, or absent altogether. The multiple goals perspective suggests that there are some ways of communicating that are better and worse or higher and lower in quality than other ways of communicating (Caughlin, 2010; Goldsmith et al., 2006; Scott & Caughlin, 2012, 2014; Van Scoy et al., 2017b). Specifically, high quality communication not only manages instrumental interaction goals but also attends to identity and relational goals that are normatively relevant to the situation (Goldsmith, 2001, 2004).

Additionally, this set of goal-based theories suggests that depending on a communicator's goals for the interaction, one conversation about a topic could be quite different from another conversation about the same topic. In the context of disclosing a mental illness, for example, consider the statement, "You're my daughter, so I thought you should know." This highlights the communicators' relationship with one another (i.e., parent-daughter) as well as the impact of that relationship on the speaker's communicative decisions (i.e., the decision to disclose). This portion of the message suggests that the speaker values the parent-child relationship and is

communicatively attending to the relational goal of maintaining that relationship (Clark & Delia, 1979; Caughlin et al., 2009). Similarly, a mental illness disclosure message that incorporates, "I don't want you to think I'm weird," indicates the speaker's concern with managing others' impressions of her and explicit attention to identity goals (Brown & Levinson, 1987; Clark & Delia, 1979). As demonstrated by these examples, the specific words communicators use to convey interaction goals can help them gain insight into their own and their conversation partner's goals for the conversation (Goldsmith, 2004). That is, what people choose to say during an interaction often illuminates their less obvious interaction goals, such as those related to self-presentation and their relationship, which provides a way for communicators to identify goal attention during interactions.

Given the various goals with which people enter into interactions as well as the numerous ways to communicatively express those goals, it is improbable that every person will talk about sensitive or stigmatized topics in the same way. For instance, if a mother had the task goal of disclosing to her YA child that there is a history of major depression in her family, there are many different ways she could verbalize or say, "Major depression runs in our family." For example, she could simply leave it at that, or she could add that, "There's nothing to worry about," "That's why my sister takes medication," and/or "We should probably get you tested for the gene." The way this parent chooses to communicatively achieve this task goal (and other relevant identity or relational goals) is connected to different individual and relational outcomes. Research suggests that variations in message characteristics are associated with communication quality, message interpretation, and responses to messages about stigmatized topics (Burleson & Goldsmith, 1998; Caughlin et al., 2008, 2009; Donovan-Kicken et al., 2013; O'Keefe & Shepherd, 1987; Scott et al., 2013). The different messages used to deliver relevant task, identity, and relational goals may work to alleviate or amplify the challenges and dilemmas of communicating about stigmatized health topics in close relationships (Donovan-Kicken et al., 2013). Although identifying and analyzing discrete message characteristics is not a focus of this study, it is an important piece of the multiple goals theoretical perspective, which highlights that

the characteristics of a message can illuminate relevant interaction goals in a specific context, can help communicators infer their own and their partner's interaction goals, and can influence communicators' responses to one another (Burleson, 1994; Donovan-Kicken et al., 2013; Goldsmith, 2004). Furthermore, the present study is a useful step toward designing research that would focus on message features, particularly in stigmatized contexts. With an emphasis on attention to relevant interaction goals, this study can help empirically identify some goals that are most relevant to the specific context of parent-YA communication about mental health, providing a foundation from which to examine the ways in which these goals are discursively pursued. Additionally, the model of stigma communication (more on this below), which guides exploration of stigma's role in this project, may provide another way for scholars to examine the message features associated with better and worse management of relevant interaction goals when stigma communication is also salient.

Overall, adopting a multiple goals perspective allows scholars to assess complex communication through attention to relevant relational, identity, and task goals and the ways in which these goals compete or conflict with one another, at times constraining goal achievement. Attention (or lack of attention) to relevant interaction goals can shape conversation satisfaction, perceptions of relational satisfaction and closeness, and individual attitudes (Caughlin, 2010; Donovan-Kicken & Caughlin, 2010; Scott & Caughlin, 2012, 2014). Communication that attends to complex combinations of goals has been considered higher in quality than messages that do not attend to relevant interaction goals (e.g., Goldsmith et al., 2006; Scott & Caughlin, 2012, 2014). Multiple goals theories have guided investigations of responses to HIV/AIDS and depression disclosures as well as the sophistication of responses to requests for help when mental illness stigma is salient (Caughlin et al., 2008, 2009; Imai & Dailey, 2016; Scott et al., 2013). The multiple goals approach also has informed exploration of supportive communication, topic avoidance, and end-of-life conversations (Donovan-Kicken & Caughlin, 2010; Goldsmith & Fitch, 1997; Goldsmith et al., 2006; Scott & Caughlin, 2012, 2014).

**Model of Stigma Communication**

Additionally, Smith's (2007, 2011) model of stigma communication (MSC) is used to highlight the communicative nature of stigma and guides examination of the ways stigma may impact goal attention during conversations about mental health. MSC extends Goffman's (1963) conceptualization of stigma as a social phenomenon by situating stigma as a communicative act that is expressed, reinforced, and learned through messages. Scheff (1971) suggested that stigma is frequently and normatively communicated in conversation through the use of metaphors without awareness or knowledge of their original meanings. Smith (2007) built from this idea by identifying specific attributes of stigma communication—distinguishing marks, labels, blame, and links to danger. These communicative cues are thought to influence reactions to and effects of (e.g., developing stigmatized attitudes toward a topic, avoiding the stigma) stigmatizing messages. MSC has primarily been used to explore mediated and mass media messages within intergroup contexts (e.g., Anderson & Bresnahan, 2013); however, this model has also been applied to interpersonal contexts (e.g., Smith, 2014).

By exploring parent-YA communication about mental health using the multiple goals perspective along with MSC, an additional way to classify communication about stigmatized health information is introduced to multiple goals theorizing. This also represents an opportunity to conceptualize conversations about mental health differently and to potentially challenge current theorizing about parent-YA communication about stigmatized topics. For instance, the presence of stigma may further complicate communicators' abilities to effectively attend to the identity and relational goals associated with already complex communication about mental health. However, because stigma related to mental health and mental illness is often normatively incorporated into the ways people talk, it may not factor into the complexity of mental health conversations. There is a lack of empirical evidence to verify these speculations. Therefore, using a multiple goals framework in combination with MSC, provides a useful way to understand how stigma contributes to or detracts from effective attention to relevant interaction goals during parent-YA conversations about mental health. Extending knowledge about how

parents and YAs effectively attend to interaction goals when talking about mental health is important because some evidence suggests that different types of talk about mental health and mental illness perpetuate stigma and are associated with more and less favorable outcomes (e.g., help seeking). Thus, using these theoretical perspectives to evaluate the extent of parent and YA attention to relevant interaction goals and the inclusion of stigma communication during conversations about mental health helps to illuminate the associations among attention to interaction goals and parent and YA conversation satisfaction, relational closeness, and clinical and non-clinical help-seeking attitudes. Each of these variables of interest are further explicated later in this chapter.

### EFFECTIVE ATTENTION TO INTERACTION GOALS

As with communication about most topics, it is often what we say and how we say it— or the *quality* of communication—rather than the *quantity* of communication that influences individual and relational outcomes (e.g., Donovan et al., 2017; Miller-Day, 2002; Miller-Day & Kam, 2010; Scott, 2010). Overall, across message types (e.g., disclosures, support provision, compliance-gaining), messages that attend to relevant (sometimes competing) goals are considered higher in quality than messages that do not attend to relevant interaction goals. That is, communication that attends to relevant interaction goals has been found to be more competent, effective, sophisticated, persuasive, appropriate, supportive, sensitive, successful, helpful, and positive than messages that do not attend to relevant interaction goals (Burleson & Samter, 1985; Caughlin, 2010; Caughlin, et al., 2008; Goldsmith, 1992, 2004; Goldsmith et al., 2006; Lambert & Gillespie, 1994; O'Keefe, 1988; O'Keefe & McCornack, 1987; O'Keefe & Shepherd, 1987; Scott & Caughlin, 2012).

Not only can individual messages and turns taken within interactions attend to relevant goals, but entire conversations can as well (e.g., Scott, 2010). Although the multiple goals perspective has primarily been used as a theory of message production, work has been done to support the utility of this approach in helping explain message interpretation (Caughlin, Scott,

Miller, & Hefner, 2009; Scott, 2010). Caughlin (2010) asserts that perceptions of interaction goals can shape meaning and "help us understand the connections among message production, communication, and relational outcomes" (p. 832). Empirical evidence has supported this claim with findings that suggest communicators' perceptions and interpretations of interaction goals affect individual and relational outcomes (e.g., Donovan-Kicken & Caughlin, 2010).

Communicators' attention to interaction goals during a given situation can be meaningfully assessed by considering interactants' *perceptions* of their own and their partner's goal pursuit or enactment. Moreover, existing scholarship has suggested that although individuals may not enter into a communicative situation with a set of interaction goals in mind, they can often detect their own and their partner's goals based on actions, communicative expression of goals, and responses to enacted or pursued goals (Bem, 1972; Caughlin & Scott, 2010, Wilson, 2007). However, some research has indicated that communication partners may perceive and report goals inaccurately. That is, perceptions of interaction partner's goals may be idiosyncratic and shaped by relational dynamics or interactions beyond the conversation of interest (Caughlin, 2010; Noller & Feeney, 2004). Some goals also may be difficult to communicatively express or achieve, impeding interactants' abilities to accurately assess their conversation partner's goals for the interaction (Tracy & Eisenberg, 1990). As such, parent and YA perceptions of their partner's goals may inaccurately reflect the actual goals interactants sought to accomplish (Floyd & Markman, 1983). Similarly, people may have inaccurate or biased perceptions of their own behaviors—inaccuracies that may be further exacerbated by health conditions or concerns (Beck, Rush, Shaw, & Emery, 1979). While perceptions of own and other's goals may not precisely align with the actual goals individuals have for a conversation, multiple goals research has demonstrated that perceptions of goals influence interpretation of, responses to, and outcomes of communication interactions, which is the focus of the present study (e.g., Donovan-Kicken & Caughlin, 2010; Scott, 2010).

A first step in evaluating parent and YA perceptions of their own and their partner's attention to interaction goals during conversations about mental health is to identify identity,

relational, and task goals germane to stigmatized health contexts and familial relationships. As the multiple goals theoretical perspective stipulates, different interaction goals will be more salient in some situations than will other interaction goals (Goldsmith, 2001, 2004). Extant research indicates that attending to goals that are normatively relevant to a given situation are evaluated as more competent and more effective, for example (Caughlin, 2010; Goldsmith, 2004). As such, some identity, relational, and task goals will be especially relevant to the context of parent-YA communication about mental health; and thus, it is expected that the more that parents and YAs attend to those salient goals, the higher in quality their conversations about mental health will be.

**Interaction Goals Relevant to Parent-YA Mental Health Communication**

While there are a number of interaction goals that may be relevant to family conversations about stigmatized health topics, politeness (i.e., positive and negative face), relational maintenance, avoidance, provision of support, and persuasion have been identified as particularly germane to this complex communicative situation. Although this is not a comprehensive list of all possible interaction goals salient to parent-YA communication about mental health, these six goals reflect existing research on relevant goals in the context of difficult health-related conversations between parents and children (e.g., Caughlin, Mikucki-Enyart, Middleton, Stone & Brown, 2011; Edwards et al., 2014; Scott, 2010; Scott & Caughlin, 2014). Therefore, the goals described below are useful for examining the quality of and associated outcomes related to parent-YA communication about mental health.

***Relevant identity goals.*** The identity goals of attending to the positive face and negative face of the interaction partner are salient to the context of parent-YA communication about mental health (Brown & Levinson, 1987; Scott, 2010). *Positive face* refers to individuals' desire to be liked, valued, accepted, and approved of by others (Brown & Levinson, 1987). During parent-YA conversations about mental health, communicators may speak in ways that aim to uphold or preserve their conversation partner's positive face. Positive face may be affirmed

through comments that express approval, affinity, or liking for the conversation partner or statements they make. For example, when Neve discloses to her father that she has started going to a support group for students with anxiety, her father might tell her that he agrees with her decision or he may articulate that he is proud of her for getting help. Both of these responses, which draw upon affirmation and affinity, suggest the father's attention to preserving Neve's positive face. Conversely, positive face may be threatened through expressions of dismissal, disapproval, rejection, or dislike of the conversation partner or his or her statements. In Neve's situation, her positive face may be threatened if her father responds by criticizing her choice to attend a support group or by ignoring her disclosure altogether, likely hindering Neve's sense of acceptance.

*Negative face* refers to individuals' desire for independence and to not be imposed upon by others (Brown & Levinson, 1987). During conversations about mental health, parents and YAs may affirm their interaction partner's negative face by demonstrating that they do not want to impose on their conversational partner or by expressing respect for their conversation partner's autonomy. For instance, if along with being proud of Neve for seeking help, her father wanted to suggest an alternative to the support group, he might add, "I've also heard that maybe individual counseling doesn't take up as much time as group counseling, if that's something you feel like trying." This comment, which includes hedging (e.g., "maybe," "if") and explicit effort to minimize the imposition on Neve (e.g., reduced time), demonstrates her father's respect for Neve's independence and ability to make her own decisions (Goldsmith & MacGeorge, 2000). As with positive face, communicators may also threaten the negative face of their interaction partners by implying burden, interrupting, questioning their interaction partner, or demanding that their interaction partner do or not do something. In the context of Neve and her father, a threat to negative face may look like Neve agreeing to try individual therapy for her anxiety but also requesting that her father set up an appointment and drive her to her the session. Such requests imply imposition and may infringe on her father's independence.

Together, these facework concepts refer to politeness, which can help indicate the extent to which competing goals are enacted during an interaction (Brown & Levinson, 1987; Goldsmith, 2004; Scott, 2010). For example, a communicator may want to educate their partner about more accurate ways of understanding the origins of mental illness. However, in an attempt to reduce threats to their partner's sense of acceptance and being valued (i.e., positive face), they may pursue the goal of preserving their partner's positive face while also attempting to educate or correct their partner's understanding. Of course, the extent to which positive face is threatened depends upon *how* these competing goals are pursued and the ways in which they are perceived or interpreted by interactants. On the other hand, it also may be difficult to infer whether or not face-saving goals have been pursued in conjunction with other relevant interaction goals. Often times the most face-saving communicative behavior is to do nothing or to engage in avoidance (Brown & Levinson, 1987; Goldsmith & MacGeorge, 2000). Similarly, face-saving or face-preserving acts may be indirectly or subtly pursued (i.e., off record), thus going unnoticed (Brown & Levinson, 1987; Goldsmith & MacGeorge, 2000). Therefore, it is clear that greater attention to face concerns does not necessarily mean more positive individual and relational outcomes since preservation of face may not be recognizable or interpreted as such. Rather, communication resulting in favorable outcomes likely requires management of positive face and negative face in relation to other task and relational goals, which further supports exploring the pursuit of specific interaction goals relevant to parent-YA communication about mental health (Goldsmith, 1992).

***Relevant relational goals.*** The goal of *maintaining the relationship* involves keeping the relationship as it currently is, typically, in a desired state (Canary & Stafford, 1994; Dindia, 2003). Communicatively, this may be expressed through affirmations of the importance of the parent-YA relationship, by demonstrating the value of the relationship, or through relational assurances (Dainton & Stafford, 1993; Stafford & Canary, 1991). Less directly, communicators may attempt to maintain their relationship by expressing positivity or engaging in small talk (Stafford & Canary, 1991). Conversational partners may affirm their relationship by explicitly

communicating about the condition of the relationship or by reinforcing the current relationship (e.g., "I love how you're always there for me"). Such reinforcement can also be as simple as using the terms "mom," "dad," "son," or "daughter."

Some ways of communicating during the dyadic conversations about mental health also may threaten or damage the parent-YA relationship. Communicators may make comments that challenge or dismiss the importance or value of the parent-YA relationship. For instance, a parent may invoke their close relationship with their YA child as a persuasive technique to get the YA to disclose a mental health concern she has been experiencing. Although this strategy may work to reassure the YA about her relationship with her parent, this relational maintenance behavior may be interpreted as manipulative when used in conjunction with the task goal of influencing. Given that parent-YA relationships also are often in renegotiation, typically to a more peer-like relationship, the goal of maintaining the relationship may play a prominent role during parent-YA conversations (Arnett, 1998, 2001). During young adulthood, YAs often establish their own beliefs, attitudes, and lifestyles that deviate from those of their parents, which may present as conflicting interaction goals (e.g., goal to disclose vs. goal to maintain privacy; Arnett, 2004). The ways in which divergent interaction goals are addressed could shift the relationship or the roles occupied by parents and YAs (e.g., Goldsmith et al., 2006).

Overall, the influence of relational maintenance strategies and interpretations of them has not strongly established that employing relational maintenance behaviors actually results in maintaining the status quo of relationships (Stafford, 2003). Some research related to relational maintenance in the context of stigmatized health concerns has also indicated that support may be perceived as a relational maintenance behavior (Haas, 2002). Therefore, while the goal of relationship maintenance may be particularly salient to parent-YA communication, communicators' perceptions of attention to this goal should be explored within this specific health and relational context.

***Relevant task goals.*** The task goals of avoidance, support provision, and persuasion have been identified as particularly germane to parent-YA communication about mental health. For

the purposes of the current investigation, the primary task goal for parents and YAs is to engage in a conversation about mental health; therefore, this is considered an implicit instrumental goal. However, *avoidance*, which occurs when communicators evade, dodge, or try not to discuss the topics at hand or those introduced by their conversation partner, is in opposition of the goal to engage. That is, rather than engaging with or elaborating on topics related to mental health, parents and YAs may display an aversion to or lack of interest in the conversation or a particular topic. Avoidance can be direct (e.g., "I won't talk about that") or indirect (e.g., changing the subject, deflecting). Although avoidance is not inherently indicative of low-quality communication (e.g., T. D. Afifi, Caughlin, & Afifi, 2007; Donovan-Kicken & Caughlin, 2010), in this context, avoidance directly contradicts the normatively-relevant goal of engaging in a conversation about mental health. Additionally, Caughlin and Scott (2010) found that avoidance can indicate a lack of management of multiple interaction goals. Some research also has found evidence of associations between topic avoidance and relational dissatisfaction (Caughlin & Golish, 2002), while other work suggests that avoidance may facilitate relational development and be associated with relational satisfaction, depending on communicator perceptions of the reason for avoidance (W. A. Afifi & Guerrero, 2000; Donovan-Kicken & Caughlin, 2010). Not only do these findings demonstrate the complicated nature of the role of avoidance in complex communicative situations, but they also help support this study's focus on parent and YA *perceptions* of attention to interaction goals.

Additionally, the goal of *providing support* refers to messages or comments that reassure communication partners, provide validation, and/or demonstrate availability to "stand by and back" conversational partners or their thoughts, beliefs, attitudes, and decisions (Goldsmith et al., 2000, p. 379; Scott, 2010). For example, if a YA indicates to their mom that they would like to see a psychiatrist to begin taking medication for their anxiety, their mom may respond by offering to go with them to their first psychiatrist appointment or to the pharmacy with them. Based on this reply, the YA should be able to assess that their mother had a goal of providing support. On the other hand, if the YA's mother replies by saying, "Nope, you are not taking

anxiety meds; that stuff will mess with your brain," the YA can likely presume that providing support of their decision to try a new way to manage anxiety was not one of their mother's goals for the conversation. The goals of seeking and providing support have been identified as relevant in other stigmatized health contexts such as disclosures of HIV status and depression as well as in difficult communicative situations like discussing lifestyle changes related to cardiac episodes (Caughlin et al., 2009; Goldsmith et al., 2006; Scott et al., 2013). Research has indicated that messages that effectively attend to relevant interaction goals are associated with more effective support provision (Caughlin et al., 2008). However, not all supportive messages or expressions of the goal to support a communication partner are interpreted as supportive (Goldsmith, 2004). Some attempts at achieving the goal to support through advice-giving, for example, can be perceived as helpful and caring or as critical and intrusive (Goldsmith & Fitch, 1997; Goldsmith et al., 2006). Again, this highlights the role of perception in managing and achieving goal attention during interactions.

Similarly, the goal to *influence* can be interpreted as supportive just as it can be perceived as controlling or critical, depending on how the goal is enacted (Goldsmith et al., 2006). The goal to influence refers to attempts to persuade or sway conversation partners and/or change their thoughts, beliefs, attitudes, or decisions (Dillard, Segrin, & Harden, 1989; Scott, 2010). This interaction goal is particularly relevant to conversations in which divisive attitudes, beliefs, decisions, or behaviors might arise. Given the stigmatized status of mental health and mental illness, communicators may find themselves attempting to persuade their communication partners to shift their preferences or beliefs. For example, a YA may want to respect his mom's decision to keep a family history of mental illness private out of fear of stigmatization, but he may also want to work toward changing his mom's beliefs so that she feels comfortable sharing this relevant medical information with family members whose health may be affected. This demonstrates a potential conflict between the task goal to persuade and the identity goal of preserving autonomy (i.e., negative face). Because interactions that include a persuasive or compliance-gaining element can implicitly or explicitly suggest that an interaction partner is

doing something wrong (i.e., threat to acceptance) or ask that an interaction partner do something differently (i.e., implying burden or imposition), pursuing the goal to influence may also present threats to identity and relational goals (O'Keefe, 1988; Wilson, Aleman, & Leatham, 1998). Some research suggests that messages that preserve identity goals such as positive and negative face are perceived as more effective at accomplishing persuasive task goals (Brown & Levinson, 1987; Goldsmith, 2004; Goldsmith et al., 2006). More generally, messages that attend to other relevant goals, rather than solely the goal to influence, also have been associated with more effective persuasion (Lambert & Gillespie, 1994). On a relational level, using positive persuasive strategies such as expressing empathy or showing interest, rather than strategies like withholding support or displaying anger to influence family members, have been associated with family members experiencing greater intimacy with one another (Pratt, Jones-Aust, & Pennington, 1993).

For the purposes of this study, then, effective attention to interaction goals during parent-YA conversations about mental health is conceptualized as occurring when communicators pursue relevant task, identity, and relational goals (Caughlin, 2010; Goldsmith et al., 2006; Scott & Caughlin, 2012, 2014; Van Scoy et al., 2017b). More specifically, high quality communication is expected to attend to identity goals that attempt to minimize threats to the conversation partner's positive and negative face, relational goals that attempt to maintain the parent-YA relationship, and task goals to engage in a conversation about mental health, to support the conversation partner, and to avoid influencing the conversation partner. The more that parents and YAs attend to these goals during conversations about mental health, the higher in quality their conversations and subsequent outcomes ought to be. Low quality communication, then, is anticipated to not attempt to attend to these relevant identity, relational, or task goals. That is, low quality communication is expected to ignore or threaten the conversation partner's positive and negative face, ignore the goal to maintain the relationship or aim to damage the parent-YA relationship, ignore the task goal of engaging in a conversation

about mental health by avoiding parts of or the entire conversation, forego providing support for the conversation partner, and attempt to exert influence over the conversation partner.

## CONSEQUENCES OF (NOT) ATTENDING TO INTERACTION GOALS

During difficult conversations, variations in communicators' management of interaction goals have been found to distinguish better from worse relational and individual outcomes (e.g., Scott & Caughlin, 2014). For example, in the context of health topics such as HIV/AIDs, end-of-life care, emotional distress, and heart health, communication that effectively attends to relevant interaction goals has been positively associated with communicators' satisfaction with messages, hopefulness, relational closeness, and positive affective and behavioral change when compared to messages that do not effectively attend to salient interaction goals (Burleson & Goldsmith, 1998; Caughlin et al., 2008; Edwards et al., 2014; Flickinger, Saha, Moore, & Beach, 2013; Goldsmith, 2004; Scott & Caughlin, 2014). Although existing research about attending to interaction goals in other stigmatized health contexts can help guide expectations about mental health conversations, there is insufficient empirical evidence about parent-YA communication about mental health topics to be certain. Because the goals and effects of communication are not static, but rather are contextually situated, it is worthwhile to investigate interaction goals present in parent-YA conversations about mental health conversations (Goldsmith, 2004). Accounting for the task, identity, and relational goals relevant to parent-YA communication about mental health will help lay the foundation for clarifying what constitutes higher and lower quality communication about this highly stigmatized topic.

### Perceptions of Attention to Interaction Goals

Because the same message can be interpreted multiple ways by different people, perceptions of the message's purpose or goals can also vastly differ (Caughlin, 2010; Sabee & Wilson, 2005). Previous theorizing and research suggest that interaction goals influence message interpretation (Berger, 2002; Sabee & Wilson, 2005; Scott, 2010; Wilson, 2007). For

instance, if a YA asks his mother if she has ever gone to counseling, the mother's interpretation of her son's question depends on the goal or purpose she assigns to his question. That is, the mother may assume her child is simply curious, perhaps that he is interested in learning about therapy, that he possibly wants to pursue counseling for himself, or that his question is a precursor to disclosure of his current therapy use (Caughlin, 2010; Venetis et al., 2017). As Caughlin (2010) stated, "Meaning is shaped, in part, by the goals that people ascribe to themselves and others in conversations. This is important because it implies that the meaning—and therefore impact—of any communication behavior can be shaped by goal inferences" (p. 832). So in this case, the meaning of the interaction can depend on the mother's interpretation of her son's goals for communicating. Although the son and mother may never explicitly discuss, address, or be fully cognizant of their own or each other's goals for communicating, perceptions of their own and each other's goals shape the ways they each interpret the message. Individuals' evaluations of messages also play a role in their responses to messages, such that these evaluations inform the ways people respond (Burleson & Goldsmith, 1998). Therefore, assessing communicators' perceptions of their own and their partner's interaction goals can account for communicator interpretations of goals.

Additionally, given the familial relationship of interest to this study, it is reasonable that parents could perceive their YAs' attention to interaction goals and use of stigma communication similarly to the ways YAs perceive their own attention to interaction goals and use of stigma communication and vice versa. That is, individuals are socialized by their families toward specific health beliefs and behaviors as well as ways of talking (or not) about certain topics (Brody et al., 1998; Koenig Kellas, 2010; Ormondroyd et al., 2008; Segrin, 2001). So in the context of communication about mental health, parents and YAs may have similar beliefs and ways of talking about the topic, potentially resulting in aligned communicator perceptions. Also, parents and their YA children likely have spent years sense-making and meaning-making with one another, resulting in personal understandings of certain behaviors (e.g., Noller & Feeney, 2004). This may facilitate concordance between perceptions of what parents were doing and

what YAs think their parent were doing as well as between what YAs were doing and what parents think their YAs were doing. Lastly, parents and YAs were given conversation topics to discuss as part of the current study. Having shared access to this specific material may help guide parent and YA joint understanding of the context of their conversation and one another's communicative behaviors. As such, the following hypotheses related to associations between parent and YA perceptions of their own interaction goals and their partner's interaction goals are posited. First, YA perceptions are considered:

**H1a$_{i}$:** YA perceptions of parent attention to the interaction goal of affirming positive face during conversations about mental health will be positively associated with parent perceptions of their own attention to the interaction goal of affirming positive face during conversations about mental health.

**H1a$_{ii}$:** YA perceptions of parent attention to the interaction goal of affirming negative face during conversations about mental health will be positively associated with parent perceptions of their own attention to the interaction goal of affirming negative face during conversations about mental health.

**H1a$_{iii}$:** YA perceptions of parent attention to the interaction goal of maintaining the relationship during conversations about mental health will be positively associated with parent perceptions of their own attention to the interaction goal of maintaining the relationship during conversations about mental health.

**H1a$_{iv}$:** YA perceptions of parent attention to the interaction goal of avoidance during conversations about mental health will be positively associated with parent perceptions of their own attention to the interaction goal of avoidance during conversations about mental health.

**H1a$_{v}$:** YA perceptions of parent attention to the interaction goal of supporting during conversations about mental health will be positively associated with parent perceptions of their own attention to the interaction goal of supporting during conversations about mental health.

**H1a$_{vi}$:** YA perceptions of parent attention to the interaction goal of influencing during conversations about mental health will be positively associated with parent perceptions of their own attention to the interaction goal of influencing during conversations about mental health.

The following hypotheses consider parent perceptions:

**H1b$_{i}$:** Parent perceptions of YA attention to the interaction goal of affirming positive face during conversations about mental health will be positively associated with YA perceptions of their own attention to the interaction goal of affirming positive face during conversations about mental health.

**H1b$_{ii}$:** Parent perceptions of YA attention to the interaction goal of affirming negative face during conversations about mental health will be positively associated with YA perceptions of their own attention to the interaction goal of affirming negative face during conversations about mental health.

**H1b$_{iii}$:** Parent perceptions of YA attention to the interaction goal of maintaining the relationship during conversations about mental health will be positively associated with YA perceptions of their own attention to the interaction goal of maintaining the relationship during conversations about mental health.

**H1b$_{iv}$:** Parent perceptions of YA attention to the interaction goal of avoidance during conversations about mental health will be positively associated with YA perceptions of their own attention to the interaction goal of avoidance during conversations about mental health.

**H1b$_{v}$:** Parent perceptions of YA attention to the interaction goal of supporting during conversations about mental health will be positively associated with YA perceptions of their own attention to the interaction goal of supporting during conversations about mental health.

**H1b$_{vi}$:** Parent perceptions of YA attention to the interaction goal of influencing during conversations about mental health will be positively associated with YA

perceptions of their own attention to the interaction goal of influencing during conversations about mental health.

**Communicative Concerns**

With the complex combinations of interaction goals and individual and relational considerations, parents and YAs may experience anxiety or apprehension related to talking with one another about personal, private, and/or stigmatized health topics like mental health. Communication apprehension, in general, relates to an "individual's level of fear or anxiety associated with either real or anticipated communication with another person" (McCroskey, 1977, p. 85). Building from this overarching concept, Lucchetti, Powers, and Love (2002), describe parent-child communication apprehension, specifically, as the anxiety or nervousness a child feels toward talking with her or his parent or parents. For the purposes of this study, this definition also was extended to relate to the apprehension or lack of ease parents might feel about talking to their YA children about certain topics. For example, if Kiki perceives that her mother does not want to talk about therapy as a viable treatment for her eating disorder, which she interprets as dismissive of relevant goals she has during the conversation, then Kiki may be apprehensive or nervous to engage with her mother. When YAs experience apprehension or anxiety about communicating with their parents, parent-YA relationships can be negatively affected, including decreases in frequency and quality of communication, trust, advice seeking, and relational satisfaction (Beatty & Dobos, 1992; Cascio, Guzzo, Pace, & Pace, 2013; Freimuth, 1976; Guerrero & W. A. Afifi, 1995; Lucchetti et al., 2002; McCroskey, 1977). Therefore, the following hypotheses related to parent-YA communication apprehension are put forth, with YA perceptions considered first:

**H2a$_i$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming positive face during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2a$_{ii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming negative face during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2a$_{iii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of maintaining the relationship during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2a$_{iv}$:** The more that YAs perceive that they and their parents attend to the interaction goal of avoidance during conversations about mental health, the more communication apprehension both YAs and parents will report.

**H2a$_{v}$:** The more that YAs perceive that they and their parents attend to the interaction goal of supporting during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2a$_{vi}$:** The more that YAs perceive that they and their parents attend to the interaction goal of influencing during conversations about mental health, the more communication apprehension both YAs and parents will report.

Next, parent perceptions are considered:

**H2b$_{i}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming positive face during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2b$_{ii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming negative face during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2b$_{iii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of maintaining the relationship during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2b$_{iv}$:** The more that parents perceive that they and their YAs attend to the interaction goal of avoidance during conversations about mental health, the more communication apprehension both YAs and parents will report.

**H2b$_{v}$:** The more that parents perceive that they and their YAs attend to the interaction goal of supporting during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H2b$_{vi}$:** The more that parents perceive that they and their YAs attend to the interaction goal of influencing during conversations about mental health, the more communication apprehension both YAs and parents will report.

**Relational Consequences**

The quality of parent-child communication impacts parents and children as well as the family as a whole (Burleson, Delia, & Applegate, 1995; Fitzpatrick & Vangelisti, 1995; Guerrero & W. A. Afifi, 1995). For instance, when parents communicate with their children by elaborating on feelings, motivations, and intentions (i.e., person-centered communication as opposed to position-centered communication), children are more self-guided and selfless (Burleson et al., 1995). Additionally, in Scott's (2010) study of parent and adult child conversations about end-of-life care, for example, when family members perceived that they and their conversation partner attended to positive and negative face, relational goals, and support, they reported less relational distancing than those who perceived attention to the task goals of avoiding and influencing.

When messages are perceived as intentionally hurtful or as representing a pattern of hurtful communication, people perceive greater relational distancing than those who consider hurtful messages unintentional (Vangelisti & Young, 2000). Messages considered intentionally hurtful are also associated with less relational satisfaction than messages that are interpreted as unintentionally hurtful. Although stigmatizing messages may not be perceived as hurtful to those who hear them, they are, in fact, damaging—both to those who are being stigmatized and

potentially to those who hear or receive the stigmatizing message (Goffman, 1963; Smith, 2007). Not only can stigma be communicatively perpetuated, it also may contribute to perceptions of less close relationships between communicators (Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018). Specifically, in terms of relational distancing, one study found that YAs who received stigmatizing messages about mental health reported significantly less close relationships with familial message sources than did YAs who received mental-health messages that normalized mental health or provided strategies for maintaining mental health (Greenwell, 2018).

In addition to the impact of communication on relationships, individuals often disclose their health information to close others including mothers and fathers (Bos et al., 2009; Greene, 2000). People who face health concerns may choose or feel obligated to share their health information with family members in order to inform, educate, or solicit support from them (Greene, 2000). Research suggests that revealing stigmatized health information, such as HIV-positive status, to family members is complicated and that disclosers often regret disclosing their personal information to family members (Derlega, Winstead, Greene, Serovich, & Elwood, 2004; Greene, 2000; Serovich, Mason, Bautista, & Toviessi, 2006). In revealing stigmatized health information, relationships may be negatively impacted by avoidance of physical contact, reduced interaction length, and increased interpersonal distance, which have been found to result in social isolation, decreased amounts of social support, and potentially inadequate healthcare for individuals with stigmatized health conditions (Silver, Wortman, & Crofton, 1990; McCarthy, Koval, & MacDonald, 1999; Muralidharan, Lucksted, Medoff, Fang, & Dixon, 2016; Pachankis, 2007; Thompson & Seibold, 1978). Family conversations about health-related issues may be particularly important if the health concern is contagious or, like many mental illnesses (e.g., depression, schizophrenia), has possible genetic factors (Bauer, 2011). Because families often serve as a major source of support for individuals experiencing health challenges, the quality of communication about personal health information within the family can help elicit various forms of care from family members (Bos et al., 2009; Venetis et al., 2017).

Although discussing stigmatized health topics within the family may have its advantages, mental illness stigma is associated with poor family functioning in families where at least one member has a diagnosed mental illness (Bos et al., 2009). For caregivers, simply thinking about mental illness stigma contributes to feelings of distress (Bos et al., 2009; Muralidharan et al., 2016). If an individual is indeed experiencing a stigmatized health issue, family members who provide support or care for this person may experience undesirable stigmatization themselves (i.e., courtesy stigma; Krupchanka et al., 2016; Park & Park, 2014). Findings related to familial experiences of courtesy stigma in health contexts highlight family member feelings of guilt, uncertainty, and loneliness and emotions such as fear and anxiety resulting from perceived, anticipated, and experienced stigma (Krupchanka et al., 2016). Family members manage experiences of courtesy stigma by concealing their loved one's stigmatized health condition and avoiding others (Krupchanka et al., 2016). Such strategies can limit family members' own access to social support and may result in further stigma felt by the individual with the stigmatized health condition.

For these reasons, during conversations about stigmatized health topics such as mental health, it is essential for communicators to consider and attend to interaction goals that emphasize their relationships with one another, which has the potential to influence the relationship (Caughlin, 2010). These relational goals often aim to manage (i.e., maintain) the relationship of the interaction partners and may be expressed through affirmations of the importance of the relationship or by demonstrating the value of the relationship (Canary & Stafford, 1994; Clark & Delia, 1979; Dindia, 2003). As such, the following hypotheses consider YA perceptions of interaction goals:

**H3a$_i$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming positive face during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3a$_{ii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming negative face during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3a$_{iii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of maintaining the relationship during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3a$_{iv}$:** The more that YAs perceive that they and their parents attend to the interaction goal of avoidance during conversations about mental health, the more relational distancing both YAs and parents will report.

**H3a$_{v}$:** The more that YAs perceive that they and their parents attend to the interaction goal of supporting during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3a$_{vi}$:** The more that YAs perceive that they and their parents attend to the interaction goal of influencing during conversations about mental health, the more relational distancing both YAs and parents will report.

The following hypotheses consider parent perceptions of interaction goals:

**H3b$_{i}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming positive face during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3b$_{ii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming negative face during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3b$_{iii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of maintaining the relationship during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3b$_{iv}$:** The more that parents perceive that they and their YAs attend to the interaction goal of avoidance during conversations about mental health, the more relational distancing both YAs and parents will report.

**H3b$_{v}$:** The more that parents perceive that they and their YAs attend to the interaction goal of supporting during conversations about mental health, the less relational distancing both YAs and parents will report.

**H3b$_{vi}$:** The more that parents perceive that they and their YAs attend to the interaction goal of influencing during conversations about mental health, the more relational distancing both YAs and parents will report.

**Identity Concerns**

In conversations, communicators not only manage the information or content they aim to share, but they also manage their own identities, or others' impressions of them, as well as the relevant identities of those with whom they are communicating (Clark & Delia, 1979). Goffman (1967) refers to this social identity or image as *face*, or "the positive social value a person effectively claims for himself by the line that others assume he has taken during a particular contact. Face is an image of self, delineated in terms of approved social attributes" (p. 5). Brown and Levinson (1987) identify two types of face that comprise this social identity: positive face and negative face. As previously outlined, *positive face* refers to individuals' desire to be liked, valued, accepted, and approved of by others, while *negative face* refers to individuals' desire for independence, autonomy, and to not be imposed upon by others (Brown & Levinson, 1987). Interactions that include giving or seeking advice, making requests, and encouraging behavior change, for instance, can threaten communicators' positive and negative face (Goldsmith, 1992; Goldsmith & MacGeorge, 2000; Goldsmith et al., 2006). For example, when Tim mentions that he and Uza, who prides herself on her mindfulness regimen, should meditate more often, his request not only implies that Uza's current meditation routine is not acceptable or

approved of (i.e., threatening her positive face), but it also suggests an increased time commitment to the activity (i.e., threatening her negative face).

Managing one's own face and the face of others can be especially challenging when conversations relate to complex or highly stigmatized topics, such as mental health or mental illness (Goldsmith, 2001, 2004). During such conversations, social attributes that supposedly deviate from the norm (e.g., mental illness, seeking professional help) may be particularly salient, creating opportunities for individuals to feel shame, stigma, judgment, defensiveness, and conflict (Goffman, 1963, 1967; Goldsmith, 2004). The positive and negative face of communicators may be threatened in such interactions by, for example, failing to confirm that people with mental illness are valued (i.e., positive face) or by imposing upon someone with mental health concerns by offering to help them find a psychiatrist (i.e., negative face).

In order to reduce threats to positive face and negative face, communicators may speak in ways that honor or preserve face through the use of specific politeness strategies and discursive features (Brown & Levinson, 1987; Goldsmith, 1992). For instance, rather than making a demand, a communicator may instead pose a question, which reduces imposition on the other person in the interaction (i.e., preserving negative face). Similarly, communicators may express ambiguity or low commitment with words like "maybe," "possibly," or "kind of" in order to reduce the burden of a request or a piece of advice (i.e., preserving negative face). In attempting to preserve positive face, communicators may highlight a common point of view, convey approval or admiration for the message recipient, or use inclusive words like "we," "our," or "together" to indicate affinity and liking (Brown & Levinson, 1987).

By employing these discursive strategies, communicators can work to avoid threatening one another's identities, which may reduce feelings of stigmatization, shame, and defensiveness during conversations about taboo or sensitive topics. In fact, previous research suggests that people tend to be more satisfied with conversations when their positive social identities are reinforced, and when people are satisfied with conversations, they are more likely to engage with that topic again (Martin, Weber, Anderson, & Burant, 2004; Scott & Caughlin, 2014).

Conversation satisfaction is related to accomplishing interaction goals and is conceptualized by Hecht (1978) as a response to the achievement of communication goals. As such, effective attention to relevant interaction goals has been associated with own and communication partner's conversation satisfaction, and communicators' perceptions of their own and their conversation partner's attention to interaction goals has been found to explain up to 10 percent of variance in conversation satisfaction (Scott, 2010). Therefore, it is predicted that:

**H4a$_{i}$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming positive face during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4a$_{ii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming negative face during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4a$_{iii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of maintaining the relationship during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4a$_{iv}$:** The more that YAs perceive that they and their parents attend to the interaction goal of avoidance during conversations about mental health, the less conversation satisfaction both YAs and parents will report.

**H4a$_{v}$:** The more that YAs perceive that they and their parents attend to the interaction goal of supporting during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4a$_{vi}$:** The more that YAs perceive that they and their parents attend to the interaction goal of influencing during conversations about mental health, the less conversation satisfaction both YAs and parents will report.

The following hypotheses consider parent perceptions of interaction goals and conversation satisfaction:

**H4b$_{i}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming positive face during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4b$_{ii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming negative face during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4b$_{iii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of maintaining the relationship during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4b$_{iv}$:** The more that parents perceive that they and their YAs attend to the interaction goal of avoidance during conversations about mental health, the less conversation satisfaction both YAs and parents will report.

**H4b$_{v}$:** The more that parents perceive that they and their YAs attend to the interaction goal of supporting during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H4b$_{vi}$:** The more that parents perceive that they and their YAs attend to the interaction goal of influencing during conversations about mental health, the less conversation satisfaction both YAs and parents will report.

**Stigma Concerns**

The ways in which people talk about stigmatized health topics, including mental health and mental illness, shape their attitudes toward those topics. For example, Flood-Grady (2016) found that family communication reinforces stigma surrounding mental illness and forms family members' understanding of mental illness. While Greenwell (2018) discovered that YAs who received stigmatizing mental-health messages from family members had significantly less positive attitudes toward clinical mental-health help seeking than YAs who received normalizing or strategizing messages about mental health. As such, the ways in which parents and YAs talk

about stigmatized health topics may serve to normalize, perpetuate, or end stigma toward the topics being discussed.

Goffman (1963) defines stigma as "an attribute that is deeply discrediting, a personal mark of disgrace, and a contaminated social identity" (pp. 2-3). This definition, which has been widely used to conceptualize and explicate what stigma is and how it functions, highlights the "undesired differentness" of individuals who possess an identity that deviates from social norms (p. 5). Goffman (1963) has classified these undesirable attributes into three categories: "abominations of the body" or physical abnormalities; "blemishes of individual character" or unfavorable personal traits, morals, or choices; and "tribal stigma" or differentness associated with connections to a particular group or community (p. 4). Additionally, Goffman (1963) has suggested that individuals with concealable or invisible stigmas are *discreditable* but are not automatically stigmatized, as are those whose stigmas are visible (i.e., the *discredited*; p. 4). While, discreditable individuals, often including those with mental illnesses and perhaps those who seek help from mental health professionals, may not be readily stigmatized, they often live with the threat of discovery, difficult disclosure decisions, and fear of negative evaluations (Choi et al., 2016; Greene, 2015; Link & Phelan, 2001, 2006; Pahwa, Fulginiti, Brekke, & Rice, 2017; Venetis et al., 2017). Research suggests that such stigma leads people to fear and avoid others who have mental illnesses (Barney et al., 2006; Corrigan, 2005; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000).

Stigma, specifically related to mental illness, has been found to relate to its visibility, aesthetics (e.g., lack of hygiene), treatability (i.e., beliefs about treatments for mental illness), opportunities for recovery, professional efficacy (i.e., beliefs that healthcare professionals can treat mental illness), interpersonal anxiety, and relationship disruption (Day, Edgren, & Eshleman, 2007; Jones et al., 1984). Together, these dimensions contribute to an individual's mental illness stigma orientation. Individuals' aversion to or stigma toward health issues impacts the ways they communicate about those topics. In a study exploring responses to HIV disclosures, for example, people who reported higher aversion to HIV wrote messages that did

not attend to the relevant interaction goals of the situation (i.e., expressive messages), whereas those with lower HIV aversion attended to relevant interaction goals in their responses (Caughlin et al., 2008).

Additionally, in order for individuals to be stigmatized, there must be others (i.e., those who fit within "normative expectations") to do the stigmatizing (Goffman, 1963, p. 2). Thus, stigma is socially situated and often communicated (Goffman, 1963; Link & Phelan, 2001, 2006; Smith, 2007, 2011). That is, stigmas not only work to identify and isolate individuals who differ from the "group" or fail to fit within socially normative boundaries, but stigmas are also discussed within the group to maintain stigmas and to socialize group members towards identifying, devaluing, and diminishing others who possess this stigmatized differentness (Flood-Grady, 2016; Goffman, 1963; Link & Phelan, 2001, 2006; Neuberg, Smith, & Asher, 2000; Smith, 2007, 2011).

Although multiple theories of stigma have been generated since Goffman's seminal work, many of which emphasize concealable stigmas (c.f., Link & Phelan, 2001; Meisenbach, 2010; Pachankis, 2007; Pescosolido, Martin, Lang & Olafsdottir, 2008; Quinn & Chaudoir, 2009), Smith's (2007, 2011) focus on stigma as communicated best serves the present study. According to the Model of Stigma Communication (MSC; Smith, 2007, 2011), in-group communication that identifies and devalues others often includes distinguishing marks, categorizing labels, attributions of responsibility, and physical or social danger related to contexts or individuals that are stigmatized. Communicative *marking* often highlights a visible characteristic considered abnormal within a particular group (Smith 2007, 2011). Categorizing others with *labels* helps to name the stigmatized group, endorse stereotypes, and showcase the differences between those who stigmatize and those who are being stigmatized (Smith, 2007, 2011). The *responsibility* component of stigma communication is comprised of individuals' agency in and choice to be part of the stigmatized group (Smith, 2007, 2011). Lastly, *danger* is communicated by associating the stigmatized individual or group with physical or social threats (Smith, 2007, 2011). Often times, danger is communicated by focusing on pain and social taboos.

As such, mental health messages that demonstrate these stigma cues may not reflect person-centeredness or perspective taking. Person-centered communication refers to the recognition and validation of another's thoughts, feelings, or emotions in ways that affirm and encourage elaboration, while communication that reflects perspective taking relates to an individual's ability to understand others' thoughts and feelings by adopting their point of view in a given situation (Batanova & Loukas, 2012; Burleson et al., 2009). Research on person-centeredness and perspective taking suggest that these ways of communicating are associated with perceptions of effective comforting and supportive communication as well as favorable relational functioning (e.g., cohesion and adaptability; Burleson & Goldsmith, 1998; Doherty & MacGeorge, 2013; Koenig Kellas et al., 2013; Koenig Kellas 2005). Flood-Grady and Koenig Kellas (2018) found that despite storytelling that reinforced mental illness stigma, YAs reported better understanding of mental illness and learning about engaging in listening and perspective-taking behaviors that promote understanding people with mental illness after hearing such stories. Communicated perspective taking, particularly expressions of understanding, in family communication about depression was found to predict YAs' mental-health help seeking, such that higher levels of understanding predicted help seeking (Flood-Grady, 2016).

Therefore, a relationship between effective attention to interaction goals and stigma is anticipated such that messages in which stigma is communicated risk threatening identity and relational goals and impeding task goals. For example, if Lex tells his mom that people who have mental breakdowns are unfit to be in the workforce (i.e., stigma communication), this is likely to threaten her positive face (i.e., her desire to be accepted and approved of) since Lex is unaware that his mom has experienced mental health concerns before. Similarly, if Davika's dad tells her that she is just making herself sad so he will not let her go to a doctor (i.e., stigma communication), Davika's autonomy (i.e., negative face) may be threatened. Thus, messages that rely on or incorporate stigma communication may be considered less effective at attending to other interaction goals, and therefore, may be lower in quality, than messages that do not include communicated expressions of stigma.

On the other hand, stigma communication about mental health and mental illness is largely normalized in the ways people talk about these topics, and it may be particularly normative within different families (Goffman, 1963; Scheff, 1971). That is, while stigma communication may threaten some communicators' identities and relationships, it may be so ingrained in the way others speak about and address these topics that identity and relational concerns may not be salient for them. For instance, if Yara's mom makes a subtle joke about "insane" Uncle Larry, which draws upon stigma related to mental illness yet is a common way that people talk, and both Yara and her mom chuckle at the joke, this may increase their perceptions of relational closeness, despite the presence of communicated stigma. If conversation partners have shared or similar ways of using stigmatizing language, then stigma communication may not threaten or constrain communicators' interaction goals. However, since stigma works to devalue and diminish the stigmatized topic, person, or group and is associated with less positive attitudes toward help seeking, it is expected that:

**H5a$_{i}$:** The less that YAs perceive that they and their parents use stigma communication during conversations about mental health, YAs will report that they and their parents perceive (1) greater attention to the interaction goal of affirming positive face, (2) greater attention to the interaction goal of affirming negative face, (3) greater attention to the interaction goal of maintaining the relationship, (4) less attention to the interaction goal of avoidance, (5) greater attention to the interaction goal of supporting, and (6) less attention to the interaction goal of influencing.

**H5a$_{ii}$:** The less that YAs perceive that they and their parents use stigma communication during conversations about mental health, the less communication apprehension both YAs and parents will report.

**H5a$_{iii}$:** The less that YAs perceive that they and their parents use stigma communication during conversations about mental health, the less relational distancing both YAs and parents will report.

**H5a$_{iv}$:** The less that YAs perceive that they and their parents use stigma communication during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H5a$_{v}$:** The less that YAs perceive that they and their parents use stigma communication during conversations about mental health, the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

The following hypotheses consider parent perceptions of the use of stigma communication:

**H5b$_{i}$:** The less that parents perceive that they and their YAs use stigma communication during conversations about mental health, parents will report that they and their YAs perceive (1) greater attention to the interaction goal of affirming positive face, (2) greater attention to the interaction goal of affirming negative face, (3) greater attention to the interaction goal of maintaining the relationship, (4) less attention to the interaction goal of avoidance, (5) greater attention to the interaction goal of supporting, and (6) less attention to the interaction goal of influencing.

**H5b$_{ii}$:** The less that parents perceive that they and their YAs use stigma communication during conversations about mental health, less communication apprehension both YAs and parents will report.

**H5b$_{iii}$:** The less that parents perceive that they and their YAs use stigma communication during conversations about mental health, the less relational distancing both YAs and parents will report.

**H5b$_{iv}$:** The less that parents perceive that they and their YAs use stigma communication during conversations about mental health, the more conversation satisfaction both YAs and parents will report.

**H5b$_{v}$:** The less that parents perceive that they and their YAs use stigma communication during conversations about mental health, the (1) more positive attitudes toward

clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**Mental Health Help-Seeking Intentions**

Each year, 59 percent of Americans who are diagnosed with a mental illness do not utilize mental health services, and those who do use such services, often delay seeking help (AMI, 2014; SAMHSA, 2015; Wang et al., 2005). Help seeking for mental health concerns is typically comprised of looking for or obtaining clinical and/or non-clinical support. Clinical help seeking refers to looking for and/or obtaining assistance from professional healthcare providers such as therapists, psychiatrists, and psychologists; whereas, non-clinical help seeking denotes looking for and/or obtaining help from personal sources such as friends, family members, and romantic partners (e.g., Eisenberg et al., 2009). Thus, mental health help-seeking attitudes are considered "evaluative reactions to seeking help for psychological" issues from either personal (i.e., non-clinical) or professional (i.e., clinical) contacts (Mackenzie, Knox, Gekoski, & Macaulay, 2004, p. 2414).

Not only can the fear of being stigmatized lead to poor health outcomes such as hypertension and chronic stress, but stigma has also been identified as a major barrier to mental health help seeking and mental healthcare, particularly for YAs (Corrigan, 2005; Eisenberg et al., 2009; James, LaCroix, Kleinbaum, & Strogatz, 1984; Link & Phelan, 2001, 2006). When stigma is related to an illness or disease, individuals may avoid disclosing illness information, seeking help, or adhering to medical treatment in order to preserve their stigma-free identities (Link & Phelan, 2006). This may be particularly true when illnesses are concealable, as is often the case with mental illness. Seeking clinical and non-clinical help, taking medication, adhering to treatment plans, or revealing problematic symptoms may be the only link between an individual and his or her concealable illness (Eisenberg et al., 2009). Although stigmatization often involves attention to and communication about *physical* markers that distinguish individuals from the group, less visible traits or behaviors such as cognitive (dys)function or help-seeking

behaviors (e.g., out-patient care) can also serve as sources of stigmatization (Golberstein et al., 2008; Mojtabai, 2007; Smith, 2007, 2011). Feelings of embarrassment and negative reactions from others, both stemming from stigma, also have been identified as barriers to help seeking for depression (Barney et al., 2006).

Along with the social stigma surrounding mental health help seeking, additional research demonstrates that communication about mental health and mental illness also impacts mental health help-seeking attitudes and behaviors (e.g., Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018). In the context of mental health messages from family members, particularly from parents, YAs' less positive attitudes toward clinical mental health help seeking were associated with messages that minimized the importance of or stigmatized mental health (Greenwell, 2018). Similarly, a willingness to seek professional help and feeling comfortable talking about personal problems with professionals positively predicted future clinical help-seeking behaviors and use of mental health treatments or healthcare services, even when controlling for previous clinical help seeking (Mojtabai, Evans-Lacko, Schomerus, & Thornicraft, 2016).

In addition to stigma's influence on help-seeking attitudes and behaviors, there is evidence that people will be more favorable toward enacting healthy behaviors when their conversations about health are more satisfying (e.g., Goldsmith et al., 2006). Recall for a moment the previously-reviewed literature suggesting that communicators tend to be more satisfied with communication that attends to face wants (Martin et al., 2004; Scott & Caughlin, 2014). However, conversations about health behavior change may be interpreted as caring and collaborative or as threats to autonomy (i.e., negative face threat) and attempts to criticize (i.e., positive face threat; Goldsmith et al., 2006). These differing perceptions can interfere with enacting such behavior changes (Goldsmith et al., 2006). These dilemmas may be mitigated through communicative attention to identity and relational goals along with attention to the task goal of encouraging healthy behaviors, such as seeking help for health concerns. Thus, the following hypotheses related to YA perceptions of interaction goals are advanced:

**H6a$_{i}$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming positive face during conversations about mental health, the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6a$_{ii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of affirming negative face during conversations about mental health, the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6a$_{iii}$:** The more that YAs perceive that they and their parents attend to the interaction goal of maintaining the relationship during conversations about mental health, the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6a$_{iv}$:** The more that YAs perceive that they and their parents attend to the interaction goal of avoidance during conversations about mental health, the (1) less positive attitudes toward clinical help seeking and (2) less positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6a$_{v}$:** The more that YAs perceive that they and their parents attend to the interaction goal of supporting during conversations about mental health, the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6a$_{vi}$:** The more that YAs perceive that they and their parents attend to the interaction goal of influencing during conversations about mental health, the (1) less positive attitudes toward clinical help seeking and (2) less positive attitudes toward non-clinical help seeking both YAs and parents will report.

Hypotheses related to parent perceptions of interaction goals are now considered:

**H6b$_{i}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming positive face during conversations about mental health, the (1)

more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6b$_{ii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of affirming negative face during conversations about mental health the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6b$_{iii}$:** The more that parents perceive that they and their YAs attend to the interaction goal of maintaining the relationship during conversations about mental health, the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6b$_{iv}$:** The more that parents perceive that they and their YAs attend to the interaction goal of avoidance during conversations about mental health, the (1) less positive attitudes toward clinical help seeking and (2) less positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6b$_{v}$:** The more that parents perceive that they and their YAs attend to the interaction goal of supporting during conversations about mental health, the (1) more positive attitudes toward clinical help seeking and (2) more positive attitudes toward non-clinical help seeking both YAs and parents will report.

**H6b$_{vi}$:** The more that parents perceive that they and their YAs attend to the interaction goal of influencing during conversations about mental health, the (1) less positive attitudes toward clinical help seeking and (2) less positive attitudes toward non-clinical help seeking both YAs and parents will report.

Taken together, previous research suggests that high quality conversations about stigmatized health topics, including mental health, should attend to relevant task, identity, and relational goals, while minimizing communicated stigmatization of the topic. That is, since stigma is related to less beneficial mental-health behaviors (e.g., isolation, barrier to mental health help seeking, associated with less positive mental health help-seeking attitudes), high

quality parent-YA communication about mental health is likely to exclude or minimize the use of stigma communication.

# Chapter 3: Methodology

Previous research has demonstrated that stigma can be perpetuated by family communication about mental health and mental illness (Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018). Research also indicates that messages about stigmatized health topics have important individual, relational, and health-related implications (e.g., Caughlin et al., 2008, 2009; Scott & Caughlin, 2012, 2014; Scott et al., 2013). However, these studies primarily have relied on data from one source (cf. Scott & Caughlin, 2012, 2014). Because communication typically involves two or more people, often with varying interpretations of the same communicative event, it is important to capture multiple experiences and perceptions of interactions. Accounting for multiple perspectives helps illuminate how conversations about stigmatized topics unfold and how variations in perceptions of attention to interaction goals influence individual and relational outcomes for both communicators. Therefore, this study explored parent-YA conversations about mental health from a dyadic perspective and utilized self- and other-reports to help illuminate the connection between the extent to which communicators perceived that they and their interaction partners attended to relevant interaction goals and relevant individual and relational outcomes. By collecting data from multiple sources, the findings from this study may more fully reflect the nature of parent-YA talk about mental health. Assessment of concordance between self and partner reports of effective attention to interaction goals, use of stigma communication, and their influence on individual and relational outcomes is also possible.

## PARTICIPANTS

Participants for this study were dyads composed of one YA (i.e., ages 18 to 24) and one of her or his parents. Although health information may be exchanged and communication about health-related topics may occur with healthcare providers, siblings, peers, and extended family members, research suggests that parents, both individually and together, are the primary sources of memorable messages and narratives about mental health and mental illness for YAs (Flood-

Grady & Koenig Kellas, 2018; Greenwell, 2018). Additionally, children have been found to desire greater depth and breadth of information about taboo health topics, such as sex, when talking with their parents (Holman & Koenig Kellas, 2018; Kirkman et al., 2005; Pistella & Bonati, 1998). Therefore, it was particularly relevant to investigate communication about mental health, a highly stigmatized topic, in the context of parent-YA relationships.

Participants included 39 dyads (78 individuals), with 21 (53.85%) mother-daughter dyads, 11 (28.21%) mother-son dyads, 6 (15.38%) father-daughter dyads, and 1 (2.56%) father-son dyad. Altogether, this yielded a sample with 59 (75.64%) females, 18 (23.08%) males, and 1 (1.28%) trans male. Parent participants ranged in age from 37 to 64 years old, with a mean age of 50.47 (*SD* = 5.83). YA participants ranged in age from 18 to 24 years old, with a mean age of 20.32 (*SD* = 1.65). The sample included White (*n* = 36, 46.75%), Hispanic or Latino/a (*n* = 21, 27.27%), Asian or Asian American (*n* = 11, 14.29%), Black or African American (*n* = 4, 5.20%) respondents, as well as participants who reported other or multiple ethnicities (*n* = 5, 6.49%). One parent participant did not report on ethnicity.

Twenty-six (66.67%) YA participants reported that they had personally experienced a mental illness, while 13 (33.33%) had not personally experienced a mental illness in their lives. Of the 26 YAs who had personally experienced mental illness, 14 (53.85%) reported currently having a mental illness diagnosis, and 10 (71.43%) of these 14 YAs reported currently managing or receiving treatment for a mental illness. A majority of YA participants (*n* = 35, 89.74%) also reported that they have had a friend, family member, or close other experience mental illness.

In the parent population, 25 participants (64.10%) reported that they had personally experienced a mental illness, with 14 respondents (35.90%) reporting that they had not personally experienced a mental illness. Of the 25 parent participants who had personally experienced mental illness, six (24%) reported currently having a mental illness diagnosis. One-hundred percent of parents (*n* = 6) who reported a current mental illness diagnosis reported that they currently manage or receive treatment for their diagnosis. As with YA participants, a

majority of parent respondents ($n$ = 34, 87.18%) reported that they have had a friend, family member, or close other experience mental illness.

## PROCEDURE

### Recruitment

Following approval from the Institutional Review Board, convenience, snowball, word-of-mouth, and purposive sampling methods were used to recruit participants in three areas of the United States—Austin, TX, Southern Indiana, and the San Francisco Bay Area. Recruitment flyers were posted or distributed in designated areas (e.g., in university courses, on approved bulletin boards, etc.) and through electronic newsletters (see Appendix A for recruitment materials). Participants who took part in the study were asked to give recruitment flyers to individuals they were already familiar with who may be interested in participating in the study as well.

Approximately 133 parent-YA dyads, primarily from Austin, TX, responded to recruitment flyers to request additional information about the study or to express interest in participating. When potential participants emailed the researcher, she explained that she only needed to meet in-person with one member of the dyad while the other dyad member could participate by calling into the session remotely. The researcher also explained that she could meet with participants in a location that the in-person participant(s) considered comfortable and convenient such as a coffee shop, study room, office, or home. If potential participants preferred another location in which to participate, a university lab space and corresponding directions were offered. As part of this same response email, the researcher indicated that if participants wanted to move ahead with the study, they could provide a few times and days that they were available to participate. The researcher also attached an electronic copy of the consent form for the study so participants could find out more information, and she encouraged potential participants to ask any questions they might have. A total of 48 parent-YA dyads initially volunteered to participate in the study. Nine dyads dropped out either before confirming their participation time or when

they did not show up to their confirmed participation session. Follow up emails were sent to each of these dyads seeking to reschedule participation sessions; however, none of the dyads opted to reschedule. This resulted in a total of 39 parent-YA dyads who fully completed the study.

Initially, the researcher aimed to recruit 60 to 85 dyads to participate in the study, based on recommendations for dyadic sample sizes when using multilevel modeling (MLM) to obtain unbiased estimates for fixed effects (Kenny, 1996, 2011; Kenny, Kashy, & Cook, 2006; Snijders, 2005). Maas and Hox (2005) suggest that estimates of regression coefficients will be unbiased when there are more than 50 clusters (i.e., dyads) at Level 2, and previous interpersonal communication studies using conversational tasks have included approximately 110 to 120 dyads (e.g., T. D. Afifi, Joseph, & Aldeis, 2008; Scott & Caughlin, 2010). However, a simulation study by Du and Wang (2016) suggests that 30 dyads are sufficient for obtaining statistically significant fixed effects when using MLM. Although Du and Wang's (2016) general recommendation is a minimum of 50 dyads, they specify that this is only necessary if 30 to 50 percent of data is missing and if intraclass correlations (ICCs) are low (i.e., .10-.29). As such, these factors were explored in the present dataset to provide direction on an appropriate number of dyads for data analysis. The present dataset contained minimal missing data (i.e., $< 5\%$), and because family members constituted the dyads for the present study, ICCs were expected to be high (Hox, 2010; i.e., $\geq .30$). Given these elements specific to the current dataset, Du and Wang (2016) recommend that "the fixed-coefficients estimates [will have] negligible bias (all relative bias was smaller than 5%) when the number of dyads is 30 or more across all studied conditions, regardless of the proportions of missing data and ICCs" (p. 26). Additionally, for studies in which participants meet with the researcher (i.e., in-lab designs rather than online only designs), "30 dyads are needed to ensure satisfactory convergence rates" even with ICCs as low as .20 (p. 26). Taking into consideration these recommendations as well as the timeline for this study, the researcher began analyzing data once 39 parent-YA dyads had completed participation in the study.

**Obtaining consent & study design**

One consent form was used to consent for the entire study (i.e., both the conversational task and the online questionnaire; see Appendix B). Participation in the study was scheduled such that the researcher could be on site with at least one member of the dyad during data collection (e.g., if both members of the dyad were not present in the same geographic location, the member who was in the same location as the researcher video conferenced or phoned the participant who was located elsewhere, and then they completed their conversational task over video conference or via phone). This allowed for greater comfort, familiarity, and flexibility for participants during the data collection process.

***Conversational task.*** Once at least one member of the dyad was in the same physical space as the researcher and the other dyad member was either co-located or remotely present for the participation session, the researcher greeted participants and briefly acquainted them with the data collection process. As part of this explanation, the researcher advised participants that they could skip over any questions or topic prompts that felt threatening or uncomfortable to discuss (Zietlow & Sillars, 1988). Similarly, the researcher explained that participants could speak for as long or as little as they would like about any topic because no time limit would be imposed for the conversation (e.g., Caughlin & Vangelisti, 1999; Scott & Caughlin, 2014). Participants were then given audio recorders, oral and written instructions for the conversation task, and six conversation topic cards. The six topic cards included instructions and conversation topics that participants were asked to discuss and the order in which to discuss them (see Appendix C). Using elicited talk, or prompting parents and YAs to engage in a conversation about mental health, served to make interaction goals, which were assessed in post-conversation questionnaires, more salient to parent and YA participants. After ensuring that participants had no more questions, the researcher then exited the immediate space in which the dyad was situated while the dyad engaged in the conversational task (i.e., the researcher was not inside the room in which the dyads completed the conversational task, but the researcher remained in a

nearby space). Parent-YA conversations about mental health ranged from 12.06 minutes to 97.05 minutes, with conversations lasting 39.51 minutes on average.

Typically, when prompting a conversation, a researcher will request that participants engage in a conversational task such as responding to multiple prompts or solving a hypothetical problem (e.g., Scott & Caughlin, 2014). For the purposes of this study, both elicited talk methods were used. That is, dyads were asked to respond to one neutral task prompt (i.e., planning a trip) as well as five topic-relevant (i.e., mental health-related) prompts (see Appendix C for topics). The first topic card was unrelated to the topic of interest to this study—mental health (see Vangelisti, Middleton, & Ebersole, 2013). This prompt asked parents and YAs to briefly plan a vacation together. This not only functioned as a warm-up discussion for participants but also could provide a baseline assessment of participants' goal attention and interaction style before they were prompted to discuss mental health. Although not included as part of this specific study, by including a neutral topic for dyads to discuss, in future data analysis it will be possible to assess potential differences in dyads' abilities to effectively attend to interaction goals when they are discussing a generic topic and when they are discussing a more difficult topic (i.e., mental health).

Following this first card (i.e., neutral task prompt), five topic cards reflecting issues pertinent to the context of mental health (i.e., topic-relevant cards) were presented to dyads. With the exception of the fifth topic-relevant card, which asked participants if there was anything else related to mental health that they would like to discuss before ending their conversation, the prompts on each card increased in topic-relevance and intensity as dyads moved through the prompts (Hines et al., 2001; Scott & Caughlin, 2014). For example, the first topic-relevant card prompted participants to define mental health and mental illness, to discuss how these health topics relate to physical health, and to outline how they take care of their own health. The fourth topic-relevant card, on the other hand, asked participants to consider the types of care they would seek out and avoid if they were to experience a short-term or long-term mental health concern, the advantages and disadvantages of these types of care, and the circumstances that would

change whether they would want a particular kind of help for a mental health concern. Given that the sequence of conversation topics was intentional, the order of topics remained consistent across dyads. These topics were intended to prompt dyads to discuss a variety of concerns, beliefs, and choices related to mental health and mental illness (e.g., Caughlin & Malis, 2004; Caughlin & Vangelisti, 1999). Using topic cards to elicit mental health conversations between parents and YAs provided some control over the variety and number of topics that dyads were asked to discuss. This method may have also increased the validity of post-conversation questionnaire items by attempting to make interaction goals and subjects such as mental-health help seeking salient to participants. Although audio-recorded data collected via the conversational task were not evaluated or coded as part of the current study, these conversations will be examined as part of future studies.

***Post-conversation questionnaire.*** Once dyads completed the conversational task, participants were instructed to alert the researcher so that she could administer separate post-conversation surveys to parents and YAs. Completion of the conversational task and the online questionnaire occurred in immediate succession. All participants who completed the conversational task then completed the online questionnaire as part of the same participation session. A secure laptop or tablet was provided to each in-person participant so that they could complete the online questionnaire, which was hosted by Qualtrics. Participants were also welcome to use their own mobile devices (e.g., smartphone, tablet) if they preferred. A secure link to the online questionnaire was sent to remote participants, and they were asked to complete the survey immediately on their own device. The post-conversation questionnaire was completed in the presence of the researcher to prevent participants from collaborating or consulting one another. The researcher was available to answer any questions face-to-face and remote participants had as they completed the questionnaire. The questionnaire asked participants to respond to items assessing conversation satisfaction, conversation realism, perceptions of own and partner's interaction goals and use of stigma communication, relational distancing, stigma orientation, clinical and non-clinical help-seeking attitudes and experiences,

mental health and mental illness conversational experience, parent-child communication apprehension, and demographic information (see Appendices D and E for questionnaire items). Overall, this questionnaire took parent and YA participants approximately 28.48 minutes (*SD* = 14.73) to complete, with a range of 9.5 minutes to 65.43 minutes.

Self- and other-report questionnaires were used to individually assess participant perceptions of their own and their conversation partner's interaction goals, use of stigma communication, and individual evaluations of the conversation about mental health. Although self-report questionnaires may introduce various biases (e.g., social desirability, social proof, etc.) into the data collection process, they provide an efficient way to collect data about participants. Collecting data via self- and other-report was intended to help account for the disadvantages of each method in order to help generate valid data and results.

Considerable research has investigated family and parent-child communication about sensitive information, including secrets, taboo topics, and stigmatized health information (e.g., Donovan et al., 2017; Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018; Holman & Koenig Kellas, 2016; Miller-Day, 2002; Miller-Day & Kam, 2010; Vangelisti, 1994; Vangelisti & Caughlin, 1997). The current investigation built on this body of research by providing an opportunity for participating dyads to engage in a conversation together and to individually report on this shared conversation immediately afterward. This design not only allowed the perspectives of both dyad members to be captured, but it also may have served to increase the salience of questionnaire items, and thus, the validity of questionnaire responses. Although the current study did not evaluate recordings of the parent-YA conversations that were collected, evaluating questionnaire data from both parent and YA perspectives can help scholars understand communication about stigmatized health topics in potentially more realistic ways. Additionally, limiting questionnaire data collection to post-conversation aimed to reduce participant priming or sensitivity to conversation topics (e.g., stigma) and to decrease the likelihood of participant fatigue. Including a pre-conversation questionnaire also could have resulted in conversational data reflecting social desirability bias regarding mental illness, stigma,

and attitudes toward clinical and non-clinical help seeking. Given this, only one questionnaire was completed by each participant *after* the conversation about mental health. After both dyad members completed their individual post-conversation questionnaire, they were asked if they had any remaining questions. The researcher also encouraged participants to contact her via email if they had any questions or concerns following their participation session. Dyads that completed the study were paid $20 ($10 per individual).

After completing the study, a majority of participants indicated to the researcher that the conversation was a positive experience for them and many thanked the researcher for the opportunity to engage their parent or child in a conversation about mental health. For example, parents and YAs alike shared comments such as, "That was fun!" "Can we sign up to do this every week?" "That was such an interesting conversation," "It will make it easier for us to talk about this again," and "This was so great; we'll definitely be talking about this stuff again." Of course, some participants did not share such comments with the researcher, but no one who participated appeared or sounded distressed after completion of the study. A number of participating dyads mentioned that their prompted conversations felt "like a continuation of a conversation we've been having for years," while a handful of other participants mentioned that they had purposefully selected to participate with a specific conversation partner in order to take the first step in talking about mental health with that person. These participants, who were primarily YAs, said that participating in this study gave them an excuse to talk to their parent and was a way to prompt a conversation they had been wanting to have.

## MEASURES

### Measures of Independent Variables

***Attention to Interaction Goals and Use of Stigma Communication.*** Attention to relevant interaction goals was measured and operationalized in two ways. Each member of the dyad reported on their perceptions of their own interaction goals and use of stigma communication (self-report) as well as on their partner's interaction goals and use of stigma communication

(other-report) during their conversation about mental health. Individual participant perceptions of their own and their partner's attention to each individual goal (i.e., affirming positive face, affirming negative face, maintaining the relationship, avoidance, support, and influence) were combined and averaged into 12 separate composite scores—six composite scores, one for each goal assessed, for each participant (i.e., YA and parent). In the same manner, individual participant perceptions of their own and their partner's use of stigma communication were combined and averaged into two separate composite scores—one composite score related to stigma communication for each participant (i.e., YA and parent).

These individual, combined self- and other- ratings that correspond to affirming positive face, affirming negative face, maintaining the parent-YA relationship, engaging with (rather than avoiding) the topic of interest (i.e., mental health), supporting the conversation partner, and not influencing the conversation partner indicate effective attention to the specific interaction goal, or higher quality communication (Caughlin, 2010; Clark & Delia, 1979; Goldsmith et al., 2006; Scott & Caughlin, 2012, 2014; Van Scoy et al., 2017b). Conversely, combined self- and other- ratings that correspond to threatening positive and negative face, damaging or neglecting the parent-YA relationship, avoiding the topic of interest (i.e., mental health), not supporting the conversation partner, and influencing the conversation partner indicate less effective attention to the specific goal, or lower quality communication. Combined self- and other- ratings of stigma communication that correspond to less stigmatization during the conversation indicate less use of stigma communication; whereas, combined self- and other- ratings of stigma communication that correspond to more stigmatization during the conversation indicate greater use of stigma communication (Smith, 2007, 2011).

***Perceptions of Self and Other Interaction Goals and Stigma Communication***

Participant perceptions of self and partner's interaction goals were evaluated with two modified instruments developed by Samp and Solomon (1998) and Dillard, Segrin, and Harden (1989). Modified versions of these instruments had also been used previously to evaluate parent and adult child end-of-life conversations (see Scott, 2010). One scale assessed perceptions of one's own interaction goals and use of stigma communication while the other scale assessed perceptions of one's partner's interaction goals and use of stigma communication. Items used to assess self and other goals were identical to one another and were deemed relevant to the conversation, relationship, and topic of interest (i.e., mental health discussion between parents and YA children). The stigma communication items were also identical and were loosely drawn from Smith's (2007, 2011) conceptualization of stigma cues.

The five-point Likert-type scales included 21 items each, with response options ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Items from the perceptions of own goals scale included: "I wanted to shift attention away from the topic of mental health and mental illness," and "I wanted to change my parent/child's mind." Items from the perceptions of partner's goals scale included: "My parent/child wanted to respect my choices," and "My parent/child wanted to avoid talking about mental health and related topics." Cronbach's (1951) alpha reliabilities, mean scores, and standard deviations for each perceived goal as reported by parents, by YAs, and by the entire sample (i.e., parents and YAs together) are separately presented in Tables 3.1 – 3.3.

Table 3.1: Descriptive Statistics for Perceived Interaction Goals Reported by Parents (n = 39)

| Perceived interaction goal | α | *Mean* | *SD* |
|---|---|---|---|
| Own goal to attend to partner's positive face | .85 | 4.29 | .60 |
| Own goal to attend to partner's negative face | -.34 | 4.15 | .40 |
| Own goal to attend to the relationship | .79 | 3.90 | .79 |
| Own goal to avoid | .93 | 1.38 | .54 |
| Own goal to provide support | .75 | 4.11 | .69 |
| Own goal to influence | .79 | 2.17 | .81 |
| Own use of stigma communication | .86 | 1.51 | .75 |
| Partner's goal to attend to positive face | .76 | 4.03 | .71 |
| Partner's goal to attend to negative face | .69 | 3.93 | .77 |
| Partner's goal to attend to the relationship | .63 | 3.48 | .88 |
| Partner's goal to avoid | .89 | 1.37 | .50 |
| Partner's goal to provide support | .72 | 3.58 | .83 |
| Partner's goal to influence | .82 | 2.09 | .86 |
| Partner's use of stigma communication | .88 | 1.44 | .69 |

Table 3.2: Descriptive Statistics for Perceived Interaction Goals Reported by YAs (n = 39)

| Perceived interaction goal | α | *Mean* | *SD* |
|---|---|---|---|
| Own goal to attend to partner's positive face | .82 | 4.39 | .67 |
| Own goal to attend to partner's negative face | .58 | 4.33 | .63 |
| Own goal to attend to the relationship | .69 | 3.99 | .82 |
| Own goal to avoid | .83 | 1.38 | .58 |
| Own goal to provide support | .63 | 4.23 | .71 |
| Own goal to influence | .71 | 2.15 | .89 |
| Own use of stigma communication | .75 | 1.48 | .70 |
| Partner's goal to attend to positive face | .88 | 4.39 | .68 |
| Partner's goal to attend to negative face | .43 | 4.42 | .57 |
| Partner's goal to attend to the relationship | .60 | 3.86 | .79 |
| Partner's goal to avoid | .69 | 1.18 | .32 |
| Partner's goal to provide support | .67 | 4.25 | .68 |
| Partner's goal to influence | .73 | 1.89 | .88 |
| Partner's use of stigma communication | .71 | 1.49 | .62 |

Table 3.3: Descriptive Statistics for Perceived Interaction Goals Reported by Parents & YAs

| Perceived interaction goal | α | *Mean* | *SD* |
|---|---|---|---|
| Own goal to attend to partner's positive face | .83 | 4.34 | .63 |
| Own goal to attend to partner's negative face | .32 | 4.24 | .53 |
| Own goal to attend to the relationship | .74 | 3.93 | .80 |
| Own goal to avoid | .88 | 1.38 | .56 |
| Own goal to provide support | .69 | 4.17 | .70 |
| Own goal to influence | .74 | 2.16 | .85 |
| Own use of stigma communication | .81 | 1.49 | .72 |
| Partner's goal to attend to positive face | .83 | 4.21 | .71 |
| Partner's goal to attend to negative face | .64 | 4.18 | .71 |
| Partner's goal to attend to the relationship | .63 | 3.67 | .86 |
| Partner's goal to avoid | .84 | 1.27 | .43 |
| Partner's goal to provide support | .75 | 3.91 | .82 |
| Partner's goal to influence | .76 | 1.99 | .87 |
| Partner's use of stigma communication | .80 | 1.47 | .65 |

Although a small number of items in a measure can contribute to low Cronbach's alpha values, all perceived interaction goal subscales included three items (Tavakol & Dennick, 2011). Some subscale reliabilities were within the acceptable range of .70 - .95, while a number of other perceived interaction goal subscales were outside the range of acceptability (Nunnally & Bernstein, 1994; Bland & Altman, 1997; DeVellis, 2003). Therefore, the researcher explored questionnaire items and patterns in the data for apparent outliers or confusion caused by item wording. Based on this inspection, it seems the negatively-worded (e.g., "didn't want to") item on the attention to negative face subscales may have hindered the ability of parent participants, in particular, to respond in ways that aligned with their responses for items 2 and 3 on that subscale.

Results of scale reliability analyses were also examined for improvement in alpha values if items were deleted. For the perceptions of partner's goal to attend to negative face subscale as well as for the perceptions of own goal to attend to negative face subscale, alpha reliabilities

improved across the parent population, the YA population, and entire sample when item 1 (i.e., "I didn't want to put pressure on my parent/child," "My parent/child didn't want to put pressure on me.") was deleted. As such, item 1 was removed from the perceptions of partner's goal to attend to negative face subscale and from the perceptions of own goal to attend to negative face subscale (see Table 3.4). Although removing this item from the attention to negative face subscales did not result in acceptable Cronbach's alpha reliabilities for each individual subscale that was assessed, it did result in improved reliability overall. For all other scales, items appeared to be worthy of retention, either resulting in a decrease in the alpha if deleted or not holding across both parent and YA populations or not resulting in consistent improvement across both measures. Table 3.4 presents Cronbach's alphas if item deleted for measures with initial alpha values below .70.

Table 3.4: Cronbach's Alpha if Item Deleted for Measures with Cronbach's Alpha Below .70

| Scale | α | Item | α if deleted |
|---|---|---|---|
| **Parent report** | | | |
| Own goal to attend to negative face | -.34 | "I didn't want to put pressure on my child." | .66 |
| Partner's goal to attend to negative face | .69 | "My child didn't want to put pressure on me." | .77 |
| Partner's goal to attend to the relationship | .63 | Deletion of any item reduces α | |
| **YA report** | | | |
| Own goal to attend to negative face | .58 | "I didn't want to put pressure on my parent." | .61 |
| Own goal to attend to the relationship | .69 | "I wanted my relationship with my parent to get stronger by talking about these issues." | .80 |
| Partner's goal to attend to negative face | .43 | "My parent didn't want to put pressure on me." | .47 |
| Partner's goal to attend to the relationship | .60 | "My parent wanted our relationship to get stronger by talking about these issues." | .70 |
| Partner's goal to avoid | .69 | "My parent wanted to change the subject away from the topic of mental health and related matters." | .76 |
| Partner's goal to provide support | .67 | "My parent was trying to reassure me." | .82 |
| **Parent and YA report** | | | |
| Own goal to attend to negative face | .32 | "I didn't want to put pressure on my parent/child." | .64 |
| Own goal to provide support | .69 | "I was trying to reassure my parent/child." | .83 |
| Partner's goal to attend to negative face | .64 | "My parent/child didn't want to put pressure on me." | .73 |
| Partner's goal to attend to the relationship | .63 | Deletion of any item reduces α | |

### *Treatment of Reported Perceptions of Interaction Goals & Stigma Communication Data*

Parent perceptions and YA perceptions of attention to each interaction goal (i.e., affirming positive face, affirming negative face, maintaining the relationship, avoidance, support, and influence) and use of stigma communication were tested in separate models in order to examine if each dyad member's individual perceptions of attention to specific goals and stigma communication was meaningful. Mathematically, this meant that a set of composite scores was

created for YA perceptions of goal attention by computing the mean score from YA perceptions of their own and their parent's attention to each goal assessed (i.e., affirming positive face, affirming negative face, maintaining the relationship, avoidance, support, and influence). This resulted in six composite scores related to total YA perceptions of goal attention—one score for each of the six interaction goals assessed. Similarly, six composite scores were created for parent perceptions of goal attention during conversations about mental health by computing the mean score from parent perceptions of their own and their YA's attention to each goal assessed (i.e., affirming positive face, affirming negative face, maintaining the relationship, avoidance, support, and influence). Again, this resulted in six composite scores related to total parent perceptions of goal attention—one score for each of the six interaction goals assessed. In total, this process resulted in 12 composite scores—(1) total YA perceptions of affirming positive face, (2) total parent perceptions of affirming positive face, (3) total YA perceptions of affirming negative face, (4) total parent perceptions of affirming negative face, (5) total YA perceptions of maintaining the relationship, (6) total parent perceptions of maintaining the relationship, (7) total YA perceptions of avoidance, (8) total parent perceptions of avoidance, (9) total YA perceptions of support, (10) total parent perceptions of support, (11) total YA perceptions of influence, and (12) total parent perceptions of influence.

This approach allowed each goal (i.e., affirming positive face, affirming negative face, maintaining the relationship, avoidance, support, and influence), as perceived by each dyad member (i.e., YA and parent) to be analyzed separately in order to assess how perceptions of attention to specific goals during parent-YA conversations about mental health were associated with the parent and YA outcome variables of interest (i.e., communication apprehension,

relational distancing, conversation satisfaction, attitudes toward clinical help seeking, and attitudes toward non-clinical help seeking).

With regard to stigma communication, composite scores were also calculated for YA perceptions of stigma communication by computing the mean score from YA perceptions of their own use of stigma and their perceptions of their parent's use of stigma communication during their conversation about mental health. A mean composite score for parent perceptions of stigma communication during the parent-YA conversation about mental health was also created. This resulted in two composite scores related to stigma communication—one score corresponding to total YA perceptions of stigma communication during their parent-YA conversation about mental health and another score corresponding to total parent perceptions of stigma communication during the same conversation about mental health. Tables 3.5 and 3.6 present descriptive statistics for total YA perceptions of their own and their partner's attention to each interaction goal and use of stigma communication and total parent perceptions of their own and their partner's attention to each interaction goal and use of stigma communication, respectively.

Table 3.5: Descriptive Statistics for Total YA Perceptions of Partner and Own Interaction Goals

| Perceived interaction goal | *Range* | *Mean* | *SD* |
|---|---|---|---|
| Goal to attend to partner's positive face | 3.00 - 5.00 | 4.39 | .57 |
| Goal to attend to partner's negative face* | 3.25 – 5.00 | 4.59 | .39 |
| Goal to attend to the relationship | 1.67 – 5.00 | 3.93 | .76 |
| Goal to avoid | 1.00 – 2.33 | 1.28 | .41 |
| Goal to provide support | 2.83 – 5.00 | 4.23 | .62 |
| Goal to influence | 1.00 – 3.83 | 2.02 | .79 |
| Use stigma communication | 1.00 – 3.67 | 1.48 | .60 |

**Note.* This calculation does not include item 1 of the negative face assessment on perceptions of partner or perceptions of own goals and stigma communication measures.

Table 3.6: Descriptive Statistics for Total Parent Perceptions of Partner and Own Interaction Goals

| Perceived interaction goal | *Range* | *Mean* | *SD* |
|---|---|---|---|
| Goal to attend to partner's positive face | 3.00 - 5.00 | 4.16 | .58 |
| Goal to attend to partner's negative face* | 3.00 – 5.00 | 4.27 | .51 |
| Goal to attend to the relationship | 1.50 – 5.00 | 3.68 | .78 |
| Goal to avoid | 1.00 – 3.00 | 1.38 | .49 |
| Goal to provide support | 2.17 – 5.00 | 3.85 | .69 |
| Goal to influence | 1.00 – 4.00 | 2.13 | .76 |
| Use stigma communication | 1.00 – 3.33 | 1.49 | .70 |

**Note.* This calculation does not include item 1 of the negative face assessment on perceptions of partner or perceptions of own goals and stigma communication measures.

## Measures of Descriptive Variables

### *Conversation Realism*

To assess the realism of participants' conversations, respondents were asked to indicate the extent to which they agreed with five statements about the conversation using seven-point Likert-type responses ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) (Scott, 2010; Scott & Caughlin, 2014). Items included "I could easily imagine having a conversation like this one on our own," and "This discussion was not natural." Similar manipulation checks have been used in previous studies utilizing conversational tasks (e.g., T. D. Afifi et al., 2008). The mean score for all participants was high, indicating that on average, both parents and YAs thought that their conversations about mental health were very realistic ($M$ = 6.13, $SD$ = .74). Cronbach's alpha reliability was acceptable across the parent population, YA population, and the entire sample (See Tables 3.7 – 3.9).

Table 3.7: Descriptive Statistics for Instruments Reported by Parents (n = 39)

| Outcome | α | *Mean* | *SD* |
|---|---|---|---|
| Conversation satisfaction | .87 | 6.38 | .59 |
| Conversational realism | .78 | 6.29 | .56 |
| Relational distancing | .74 | 1.86 | 1.17 |
| Parent-YA communication apprehension | .82 | 1.77 | .48 |
| Clinical help-seeking attitudes | .88 | 5.43 | .77 |
| Stigma orientation* | .45 | 2.86 | .70 |

**Note.* The full stigma orientation scale includes 28 items with seven subscales assessing distinct stigma-related constructs.

Table 3.8: Descriptive Statistics for Instruments Reported by YAs (n = 39)

| Outcome | α | *Mean* | *SD* |
|---|---|---|---|
| Conversation satisfaction | .90 | 6.44 | .65 |
| Conversational realism | .75 | 5.96 | .85 |
| Relational distancing | .77 | 1.74 | .78 |
| Parent-YA communication apprehension | .82 | 1.98 | .59 |
| Clinical help-seeking attitudes | .88 | 5.38 | .82 |
| Stigma orientation* | .38 | 2.50 | .62 |

**Note.* The full stigma orientation scale includes 28 items with seven subscales assessing distinct stigma-related constructs.

Table 3.9: Descriptive Statistics for Instruments Reported by Parents & YAs (n = 78)

| Outcome | α | *Mean* | *SD* |
|---|---|---|---|
| Conversation satisfaction | .88 | 6.41 | .62 |
| Conversational realism | .77 | 6.13 | .74 |
| Relational distancing | .75 | 1.79 | .99 |
| Parent-YA communication apprehension | .82 | 1.88 | .54 |
| Clinical help-seeking attitudes | .88 | 5.40 | .79 |
| Stigma orientation* | .46 | 2.68 | .68 |

**Note.* The full stigma orientation scale includes 28 items with seven subscales assessing distinct stigma-related constructs.

### *Mental Health Conversational Experience*

Participants were asked to indicate their experience with mental health and mental illness conversations by reporting the approximate number of conversations they have had about mental health topics with their participating partner, other family members, and their doctors (Hines et al., 2001; Scott, 2010). Although definitions of mental health and mental illness were included along with these items to help differentiate the topics, many participants asked about the difference between these topics of conversation and verbally shared with the researcher that these health topics often arise together in conversations. Most participants reported having engaged in more than 10 previous conversations about mental health and mental illness with their participation partner and more than 10 previous conversations about mental health with other family members. However, a majority of participants reported having two or fewer conversations about mental health with any of their healthcare providers. Reported frequencies are presented in Table 3.10.

Table 3.10: Frequencies of Reported Mental Health Conversational Experience (n = 78)

| Number of Conversations | With partner (mental health) | With partner (mental illness) | With family | With doctors |
|---|---|---|---|---|
| None | 5 | 7 | 4 | 19 |
| 1 - 2 | 14 | 14 | 3 | 23 |
| 3 - 5 | 15 | 15 | 7 | 6 |
| 6 -10 | 16 | 13 | 11 | 8 |
| 11-25 | 10 | 8 | 16 | 11 |
| More than 25 | 18 | 21 | 37 | 11 |

***Previous Clinical and Non-Clinical Help-Seeking Experience***

Participants also were asked to report on their previous experience seeking clinical and non-clinical help for mental illness by indicating whether or not they sought help from a list of clinical and non-clinical sources (e.g., therapist, family member, friend, colleague, etc.) in the past 12 months (Eisenberg, Golberstein, & Gollust, 2007; Mechanic & Bilder, 2004; Wells, Strum, & Burnam, 2004). Items and procedures for this measure were adapted from Rickwood, Deane, Wilson, and Ciarrochi (2005) and Wells, Strum, and Burnam (2004). On average, in the past 12 months, participants had most frequently sought help for a mental illness from a friend (i.e., non-clinical source). In terms of clinical sources, participants most frequently reported seeking help from a therapist within the past 12 months. Frequencies for each type of clinical and non-clinical source are reported in Table 3.11.

Table 3.11: Frequencies of Reported Clinical and Non-Clinical Mental Health Help-Seeking Experience

| Source of Help | Parent | YA | Parent & YA |
|---|---|---|---|
| Non-clinical source | | | |
| Participation partner | 10 | 26 | 36 |
| Romantic partner | 15 | 17 | 32 |
| Another child/parent | 7 | 13 | 20 |
| Mother | 5 | 19 | 24 |
| Father | 0 | 11 | 11 |
| Sibling | 6 | 14 | 20 |
| Friend | 13 | 30 | 43 |
| Classmate | NA | 8 | 8 |
| Colleague | 6 | 4 | 10 |
| Supervisor | 1 | 5 | 6 |
| Instructor | NA | 3 | 3 |
| Religious/spiritual advisor | 1 | 7 | 8 |
| Coach | 1 | 1 | 2 |
| Online support group | 3 | 3 | 6 |
| Offline support group | 3 | 4 | 7 |
| Phone help line | 0 | 4 | 4 |
| Other | | 0 | |
| Self-help book | 1 | NA | 1 |
| Clinical Source | | | |
| Physical health doctor | 9 | 7 | 16 |
| Therapist | 6 | 14 | 20 |
| Counselor | 4 | 12 | 16 |
| Psychologist | 2 | 5 | 7 |
| Psychiatrist | 5 | 6 | 11 |
| None | 1 | 0 | 1 |

### *Stigma Orientation Toward Mental Illness*

Participants' stigma orientation toward general mental illness was assessed with a revised version of the 28-item, seven-point Likert-type Mental Illness Stigma scale (Day et al., 2007). This scale is comprised of seven subscale factors associated with stigma: Treatability, Visibility,

Recovery, Professional Efficacy, Hygiene, Anxiety, and Relationship Disruption. In an effort to minimize participant fatigue, one item from each subscale was used for this study (i.e., seven items total). Items included: "There is little that can be done to control the symptoms of mental illness," "I probably wouldn't know that someone has a mental illness unless I was told," and "I feel nervous and uneasy when I'm near someone with a mental illness." Response options for this scale ranged from 1 (*completely disagree*) to 7 (*completely agree*). Previous research determined acceptable scale reliability for all factors (α = .71 - .90); however, given that only one item from each disparate subscale was used to assess stigma orientation as part of the current study, Cronbach's alpha reliabilities for the scale including all seven items were not within acceptable range for the parent population, YA population, or the entire sample (See Tables 3.7 – 3.9). The mean score for all participants was 2.68 (*SD* = .68), indicating that overall, parents and YAs have relatively low levels of stigma orientation toward general mental illness. On average, YAs scored 2.50 (*SD* = .62), and parents scored slightly higher with a mean score of 2.86 (*SD* = .70).

## Measures of Dependent Variables

### *Conversation Satisfaction*

Satisfaction with the conversation about mental health was based on a seven-point Likert-type scale (Hecht, 1978). Participants were asked to respond to seven statements about the conversation about mental health in which they just engaged. Items included "I was dissatisfied with the conversation," "I wish we had not had this conversation," and "Having this conversation was productive." Response options ranged from 1 (*strongly disagree*) to 7 (*strongly agree*). Cronbach's alpha reliability was acceptable across the parent population, YA population, and the

entire sample. Alpha reliabilities, mean scores, and standard deviations are presented in Tables 3.7 – 3.9.

***Relational Distancing***

A five-item, seven-point semantic differential scale developed by Vangelisti and Young (2000) assessed perceptions of relational distancing as it relates to parent-YA conversations about mental health. Items were: distant-close, relaxed-tense, hostile-friendly, intimate-remote, and closed-open. Cronbach's alpha reliability was acceptable across the parent population, YA population, and the entire sample. Alpha reliabilities, mean scores, and standard deviations are presented in Tables 3.7 – 3.9.

***Child-Parent Communication Apprehension***

Participants were asked to respond to a modified version of Lucchetti, Powers, and Love's (2002) 12-item Child-Parent Communication Apprehension (C-PCA) Likert-type scale. This instrument assessed anxiety levels experienced by parents and YAs with regard to communicating with their YA or parental conversation partner during their conversation about mental health. Items included "I was looking forward to talking about mental health with my parent/child," "I was tense about developing an in-depth conversation about mental health with my parent/child," and "I had no fear telling my parent/child exactly how I felt about the topics that came up during our conversation about mental health." Response options ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Cronbach's alpha reliability was acceptable across the parent population, YA population, and the entire sample. Alpha reliabilities, mean scores, and standard deviations are presented in Tables 3.7 – 3.9.

### *Clinical Help-Seeking Attitudes*

Attitudes toward seeking help for mental health concerns were assessed with the 24-item Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; Mackenzie et al., 2004). This Likert-type scale was comprised of three subscales: psychological openness, help-seeking propensity, and indifference to stigma. Psychological openness was measured with eight items including, "Mental health concerns, like many things, tend to work out by themselves," and "People should work out their own problems; getting professional help should be a last resort." Help-seeking propensity was also measured with eight items, such as, "If I believed I were having a mental breakdown, my first inclination would be to get professional attention," and "I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family." Finally, eight items measured indifference to stigma, including, "Having been mentally ill carries with it a burden of shame," and "I would feel uneasy going to a professional because of what some people would think." Response options ranged from 1 (*strongly disagree*) to 7 (*strongly agree*). Cronbach's alpha reliability was acceptable across the parent population, YA population, and the entire sample. Alpha reliabilities, mean scores, and standard deviations are presented Tables 3.7 – 3.9.

### *Non-Clinical Help-Seeking Attitudes*

Attitudes toward non-clinical help seeking were assessed with two multiple-choice items adapted from Eisenberg et al. (2007, 2009). Non-clinical help seeking is considered help, support, or counsel sought from non-clinical sources such as family members, friends, coworkers, romantic partners, religious or spiritual contacts, online or face-to-face support groups, or professors, for example. Items were: "If you were experiencing a mental health concern, from who would you seek counseling or support?" and "If you/your child had a mental

health problem that was affecting your/his or her academic performance, which people at school would you talk to/suggest your child talk to?" It is important to note that "Other (please specify)" was a response option for both non-clinical help-seeking items. However, all "other" responses were considered clinical, rather than non-clinical, sources of help and were therefore not include when calculating participant scores for non-clinical help-seeking attitudes. Because this instrument allowed respondents to select multiple responses, Cronbach's alpha reliability was not calculated. Participant scores were computed by adding the 11 non-clinical source options to obtain one overall score from 0 (*did not select any non-clinical help-seeking sources)* to 11 (*selected all non-clinical help-seeking sources*) for each participant. Higher scores indicated more positive non-clinical help-seeking attitudes. Scores ranged from 1 to 10, with average participants reporting that they would seek support from 4.51 (*SD* = 2.06) non-clinical sources. The mean score was 4.97 (*SD* = 2.12) for YAs and 4.05 (*SD* = 1.99) for parents. Frequencies for each type of non-clinical help-seeking source are presented in Table 3.12.

Table 3.12: Frequencies of Reported Non-Clinical Help-Seeking Attitudes

| Source of Help | Parent | YA | Parent & YA |
|---|---|---|---|
| Friend | 20 | 31 | 51 |
| Family member | 24 | 35 | 59 |
| Romantic partner | 17 | 24 | 41 |
| Religious/spiritual advisor | 14 | 9 | 23 |
| Support group | 10 | 16 | 26 |
| None | 0 | 1 | 1 |
| Professor | 21 | 23 | 44 |
| Academic advisor | 26 | 21 | 47 |
| Faculty member | 3 | 7 | 10 |
| Teaching assistant | 2 | 13 | 15 |
| Student services | 15 | 12 | 27 |
| Dean of Students | 6 | 3 | 9 |
| None | 1 | 5 | 6 |

# Chapter 4: Results

This chapter begins with a summary of preliminary analyses related to all hypotheses. Then, results of primary analyses are put forth. Specifically, findings related to associations among parent-reported and YA-reported perceived interaction goals, including perceived use of stigma communication, ($H1a_i$ – $H1b_{iv}$) are presented. Following this, findings related to associations between perceived interaction goals, including perceived use of stigma communication, and reported individual and relational outcomes ($H2a_i$ – $H6b_{iv}$) are displayed.

## PRELIMINARY ANALYSES

### Confirmatory factor analyses

Confirmatory factor analyses (CFA) were conducted to test the expected factor structures of two instruments assessing own and partner perceptions of interaction goals and stigma communication (Harrington, 2009; Levine, 2005). Although these instruments were intended to measure conceptually distinct latent variables (e.g., affirming positive face, attending to relational maintenance), it was plausible that some similarity would exist among constructs (e.g., affirming positive face and the goal to support). Based on the multiple goals perspective and model of stigma communication, a seven-factor solution for both measures was tested, with three distinct items loading on each of the following factors: affirming positive face, affirming negative face, maintaining the relationship, goal to avoid, goal to support, goal to influence, and use of stigma communication. In order to explore the consistency between the measurement of latent variables and conceptual expectations, goodness of fit for each instrument was tested using Amos for SPSS.

In assessing goodness of fit of the expected models to the data, numerous fit indices were provided. For the perceptions of own interaction goals and stigma communication measure, a second-order structure with observed variables loading onto seven separate, correlated latent factors on a larger construct—perceptions of attention to interaction goals—was initially tested. The $\chi^2$ goodness of fit statistic was significant ($\chi^2(168) = 330.10$, $p = .00$). This indicated that

the fit of the model to the data was not ideal. Additionally, the $\chi^2$ to degrees of freedom ratio value—another reliable goodness of fit index that accounts for sample size—was 1.97, which also suggests poor fit (Bollen, 1989). The root mean square error of approximation (RMSEA) value was also inspected for goodness of fit (RMSEA = .11). Byrne (1996) describes that RMSEA values of less than .05 to .10 reflect excellent to moderate fit, respectively, and that values greater than .10 indicate poor model fit. The comparative fit index (CFI) value, which is not as sensitive to sample size, was also reviewed (CFI = .80). CFI values of .90 or higher suggest excellent fit, and values closer to 1.00 reflect better fitting models. Lastly, the Tucker-Lewis index (TLI; Tucker & Lewis, 1973), which is a suitable measure of fit for smaller sample sizes, was inspected (TLI = .73). TLI values higher than .90 indicate satisfactory model fit. Taken together, these fit indices suggested poor model fit to the data for the seven-factor model of the perceptions of own interaction goals and stigma communication instrument. Similarly, goodness of fit results for the perceptions of partner interaction goals and stigma communication measure indicated poor model fit to the data ($\chi^2(168) = 261.23$, $p = .00$, $\chi^2/df = 1.56$, RMSEA = .09, CFI = .87, TLI = .82). Figures 4.1 and 4.2 display these initial seven-factor models with standardized factor loadings.

Figure 4.1: Seven-factor model of perceptions of own attention to interaction goals and stigma communication with standardized factor loadings.

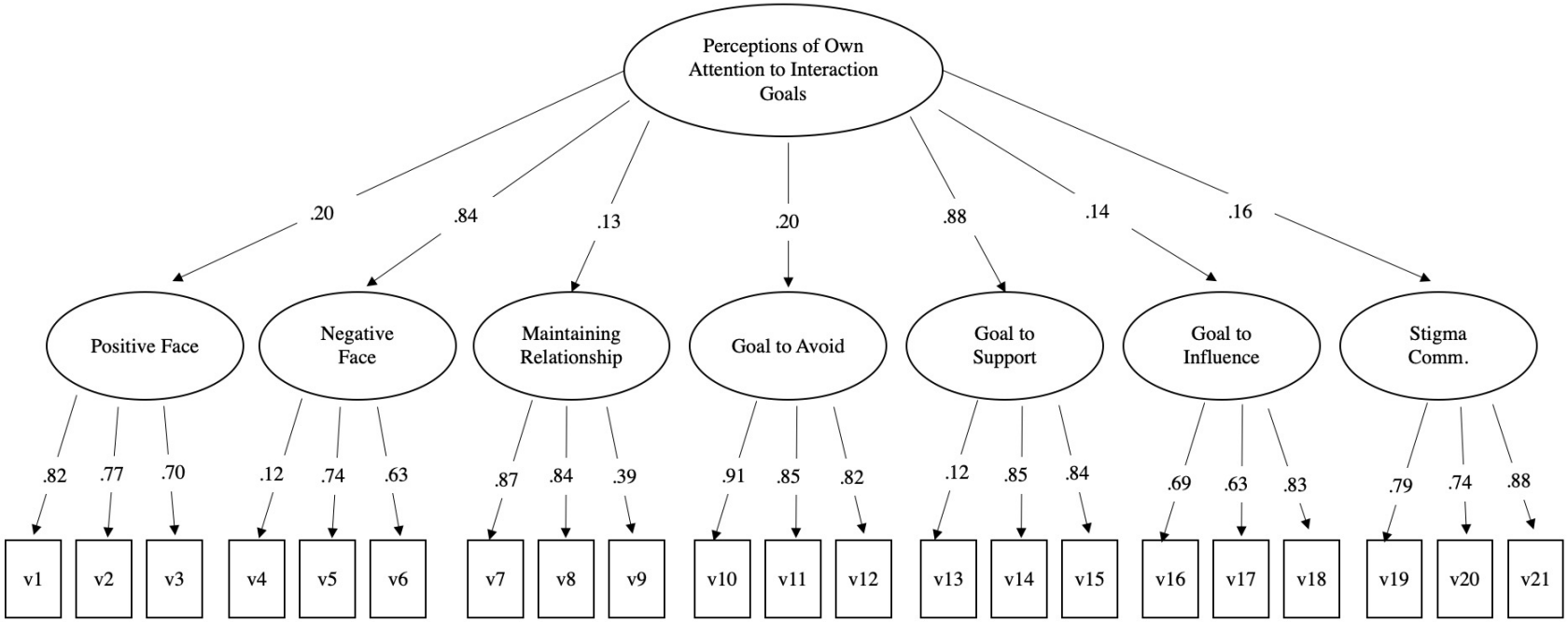
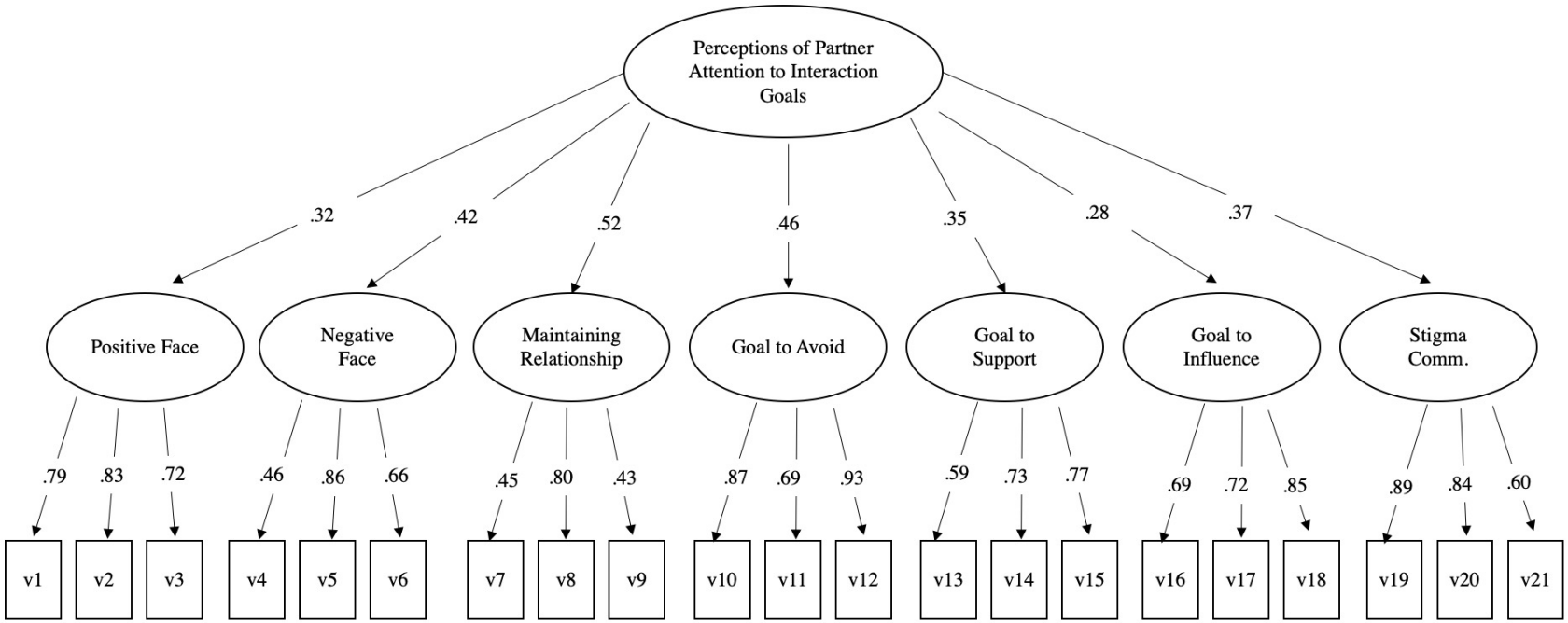


Figure 4.2: Seven-factor model of perceptions of partner attention to interaction goals and stigma communication with standardized factor loadings.



Upon review of the logic of each observed variable (i.e., items) and each latent variable (i.e., affirming positive face, affirming negative face, maintaining the relationship, goal to avoid, goal to support, goal to influence, and use of stigma communication) as they related to the overall latent variable (i.e., perceptions of own attention to interaction goals or perceptions of partner attention to interaction goals), it became clear that although stigma communication items were included as part of these measures, they assessed perceptions of the use of stigma communication rather than the goal to stigmatize. Thus, perceptions of the use of stigma communication latent variable was determined to be practically and conceptually distinct from the overarching latent variable of perceptions of attention to interaction goals. Additionally, the potential similarity among constructs (e.g., affirmation of positive face and the goal to support) was further examined, resulting in the decision to reassess goodness of fit for a three-task-goal model and a two-identity-goal model for each measure of interest. However, given the small number of observed variables (i.e., three items) associated with the single relational goal (i.e., maintaining the relationship) as well as the small number of items associated with the use of stigma communication latent variable, probabilities and goodness of fit indices could not be computed due to just-identified or saturated models, which cannot be falsified (Kenny & Milan, 2011).

As such, for each instrument assessing perceptions of attention to interaction goals and stigma communication, CFAs were conducted to test the following adjusted factor structures: (1) a second-order task-goal structure with three observed task-goal items on their respective, expected latent task goal factors (i.e., goal to avoid, goal to support, goal to influence) and (2) a second-order identity-goal structure with three observed identity-goal items on their respective, expected latent identity goal factors (i.e., affirmation of positive face and affirmation of negative face). Figures 4.3-4.6 display each of these models with standardized factor loadings. CFA results for the perceptions of own attention to task goals model were as follows: $\chi^2(24) = 28.70$, $p = .23$, $\chi^2/df = 1.20$, RMSEA = .05, CFI = .98, TLI = .97. Fit indices for the perceptions of own attention to identity goals model were: $\chi^2(8) = 14.17$, $p = .08$, $\chi^2/df = 1.77$, RMSEA = .10, CFI =

.96, TLI = .88. Results for the perceptions of partner attention to task goals model were: $\chi^2(24) = 34.76$, $p = .07$, $\chi^2/df = 1.45$, RMSEA = .08, CFI = .95, TLI = .91. Fit indices for the perceptions of partner attention to identity goals model were as follows: $\chi^2(8) = 9.40$, $p = .31$, $\chi^2/df = 1.18$, RMSEA = .05, CFI = .99, TLI = .98. For both instruments, the three- and two-factor models specifying task and identity goals demonstrated adequate fit to the data. Fit statistics for all models are presented in Table 4.1.

Table 4.1: Confirmatory Factor Analysis Fit Statistics for Perceptions of Own and Partner Interaction Goals and Stigma Communication

| Model | $\chi^2$ | df | *p*-value | $\chi^2/df$ | CFI | TLI | RMSEA |
|---|---|---|---|---|---|---|---|
| Seven-Factor Model (Own) | 330.10 | 168 | .00 | 1.97 | .80 | .73 | .11 |
| Seven-Factor Model (Partner) | 261.23 | 168 | .00 | 1.56 | .87 | .82 | .09 |
| Three-Task-Goal Model (Own) | 28.70 | 24 | .23 | 1.20 | .98 | .97 | .05 |
| Two-Identity-Goal Model (Own) | 14.17 | 8 | .08 | 1.77 | .96 | .88 | .10 |
| Three-Task-Goal Model (Partner) | 34.76 | 24 | .07 | 1.45 | .95 | .91 | .08 |
| Two-Identity-Goal Model (Partner) | 9.40 | 8 | .31 | 1.18 | .99 | .98 | .05 |

Figure 4.3: Three-factor model of perceptions of own attention to task goals with standardized factor loadings.

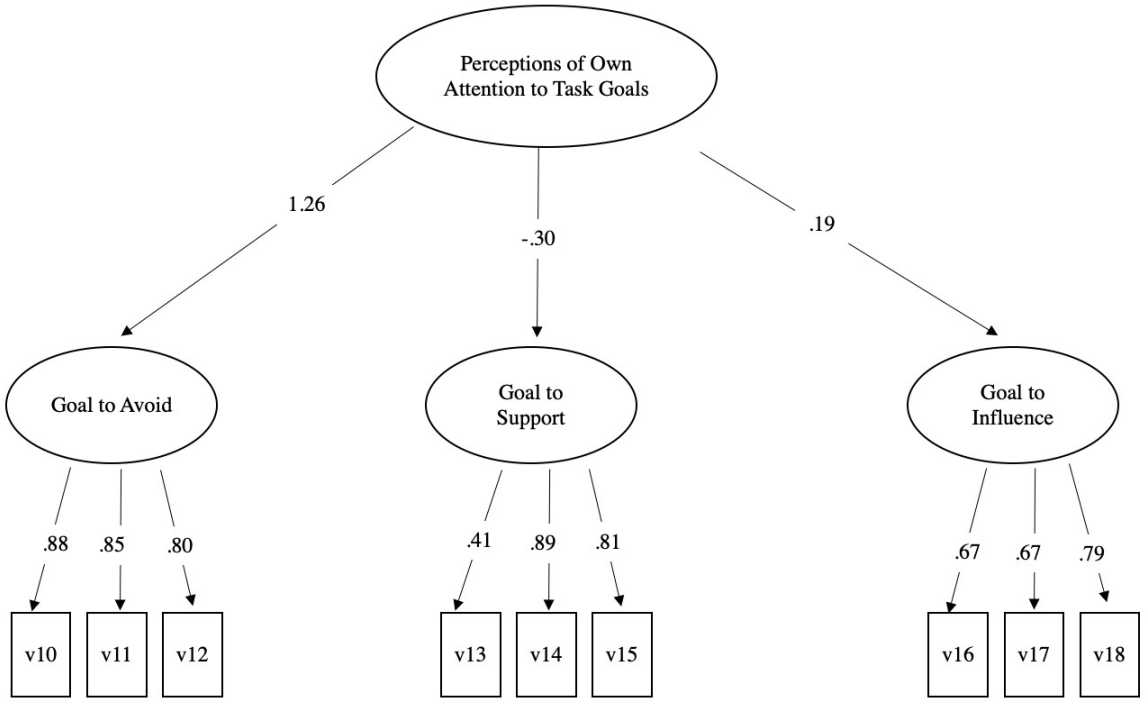


Figure 4.4: Three-factor model of perceptions of partner attention to task goals with standardized factor loadings.

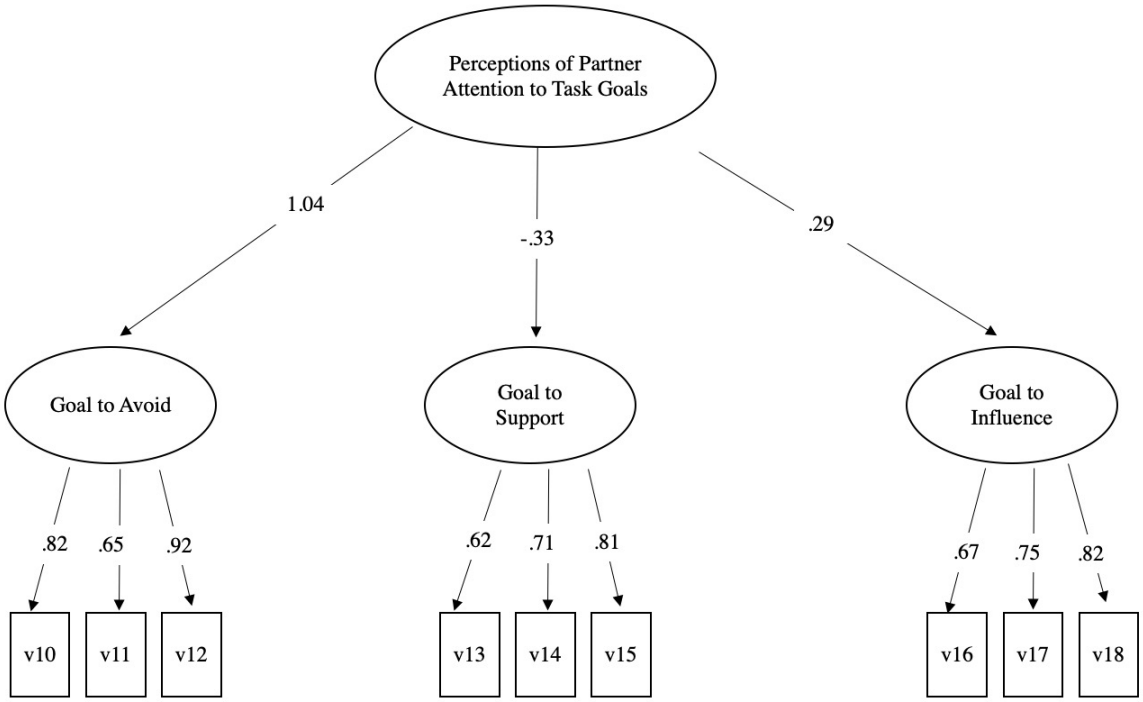


Figure 4.5: Two-factor model of perceptions of own attention to identity goals with standardized factor loadings.

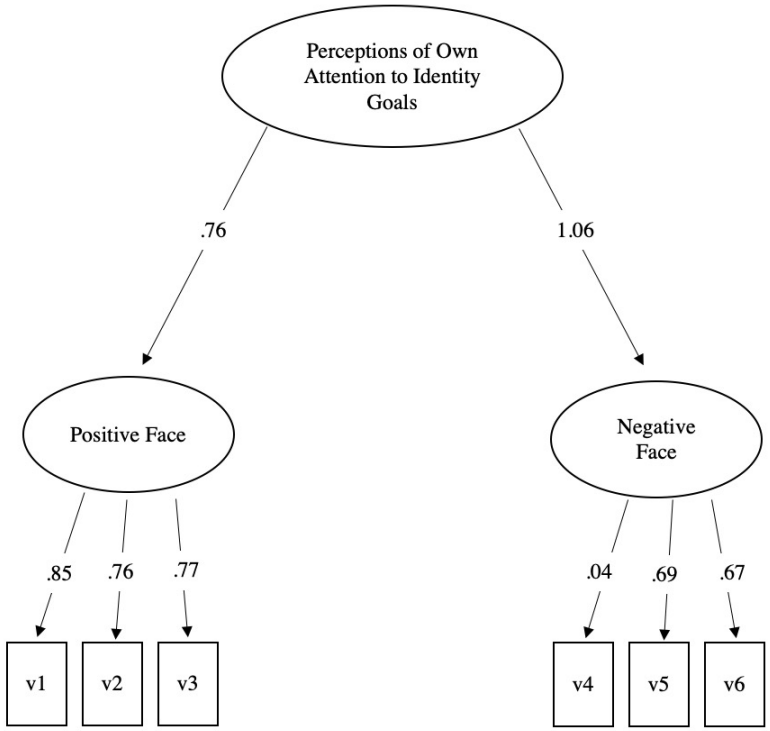
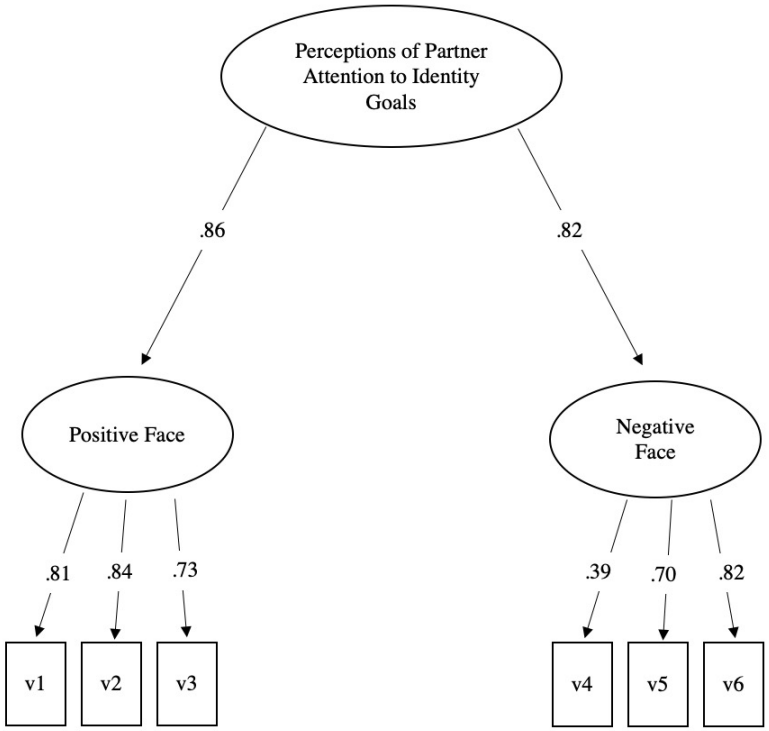


Figure 4.6: Two-factor model of perceptions of partner attention to identity goals with standardized factor loadings.



**Correlations Among YA and Parent Perceptions**

First, correlations were calculated to explore relationships between parent perceptions of their own and their partner's (i.e., YA) interaction goals and stigma communication as well as the relationships between YA perceptions of their own and their partner's (i.e., parent's) interaction goals and stigma communication (see Table 4.2). With the exception of both parent and YA perceptions of affirmation of negative face, results demonstrated that parent perceptions of their own and their partner's interaction goals were highly correlated, as were YA perceptions of their own and their partner's interaction goals. These results supported the plan to create goal- and stigma communication-related variables by taking the mean of parent perceptions of their own attention to interaction goals and their partner's attention to interaction goals to get a total parent perception score for each goal assessed and the use stigma communication. Separately, these results also supported creation of total YA perceptions scores for each goal assessed by taking the mean of YA perceptions of their own and their partner's attention to interaction goals and stigma communication.

Table 4.2: Correlations Among YA Perceptions of Their Own and Their Partner's Interaction Goals and Stigma Communication and Among Parent Perceptions of Their Own and Their Partner's Interaction Goals and Stigma Communication

| Perception of Partner Interaction Goals | Perception of Own Interaction Goals | |
|---|---|---|
| | Parent Report | YA Report |
| Attention to positive face | .58** | .42** |
| Attention to negative face | .25 | .28 |
| Attention to relationship | .73** | .78** |
| Goal to avoid | .80** | .58** |
| Goal to support | .64** | .54** |
| Goal to influence | .64** | .61** |
| Use of stigma communication | .87** | .64** |

* $p < .05$, ** $p < .01$

Given that conversational data was collected dyadically and that dyad members were part of the same family, data were considered nested (Kenny et al., 2006). Thus, it was anticipated that data would also be dependent (i.e., that between-person correlations would be significant, indicating nonindependence of data). Therefore, as an initial step in determining whether or not data were dependent, zero-order correlations were calculated among reported total perceived interaction goal variables (i.e., positive face, negative face, relationship, avoidance, support, influence), including use of stigma communication, and reported dependent variables (i.e., conversation satisfaction, help-seeking attitudes, communication apprehension, relational distancing, non-clinical help-seeking attitudes). Within-individual (for parent and YA) and within-dyad (between parent and YA) correlations provided statistical assessment of data independence by allowing for exploration of the interrelationships among variables. Along with helping to assess the interrelationships of the variables of interest, correlational findings are presented for descriptive purposes. Correlations among the reported perceived interaction goal variables, including stigma communication, are displayed in Table 4.3. Correlations among the reported dependent variables are presented in Table 4.4. With the exception of statistically significant correlations between total parent perceptions and total YA perceptions of the goal to avoid ($r = .45$, $p < .01$) and parent and YA reports of clinical help-seeking attitudes ($r = .35$, $p < .05$), all between-person correlations were non-significant, suggesting that the data were not dependent. As such, testing hypotheses using an analytic technique that accounts for nonindependent data (e.g., MLM) was not an appropriate fit for these data.

Table 4.3: Correlations Among Total Perceived Interaction Goals and Stigma Communication Variables (IVs)

| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| 1 Attention to positive face | **.03** | *.55*** | *.36** | *-.28* | *.67*** | *.07* | *-.35** |
| 2 Attention to negative face | .79*** | **.27** | *.54*** | *-.54*** | *.41*** | *-.31* | *-.53*** |
| 3 Attention to the relationship | .63*** | .56*** | **.05** | *-.33** | *.44*** | *-.01* | *-.10* |
| 4 Goal to avoid | -.37* | -.30 | -.04 | **.45**** | *-.24* | *.30* | *.64*** |
| 5 Goal to provide support | .75*** | .66*** | .73*** | -.26 | **.08** | *.10* | *-.17* |
| 6 Goal to influence | -.20 | -.16 | .24 | .28 | -.00 | **.05** | *.36** |
| 7 Use of stigma communication | -.18 | -.15 | .03 | .89*** | -.14 | .21 | **.22** |

*Note.* Results for parents are presented below the diagonal. Results for YAs are presented above the diagonal. Correlations between parent-reports and YA-reports are presented along the diagonal. Variables related to YAs represent composites of YA perceptions of their own and their partner's (i.e., parent's) attention to each individual goal and stigma communication. Variables related to parents represent composites of parent perceptions of their own and their partner's (i.e., YA's) attention to each individual goal and stigma communication.
* $p < .05$, ** $p < .01$

Table 4.4: Correlations Among Reported Dependent Variables

| Variable | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 1 Conversation satisfaction | **.25** | *.24* | *-.37** | *-.55*** | *.33** |
| 2 Clinical help-seeking attitudes | .43*** | **.35*** | *-.26* | *-.10* | *.08* |
| 3 Communication apprehension | -.59*** | -.52*** | **.25** | *.60*** | *.02* |
| 4 Relational distancing | -.60*** | -.59*** | .52*** | **-.01** | *-.26* |
| 5 Non-clinical help-seeking attitudes | .12 | .31 | -.27 | -.23 | **.29** |

*Note.* Results for parents are presented below the diagonal. Results for YAs are presented above the diagonal. Correlations between parent-reports and YA-reports are presented along the diagonal.
* $p < .05$, ** $p < .01$

Additionally, intraclass correlations (ICCs) were calculated to evaluate the amount of variance in predicted variables that were accounted for by between-dyad differences. The strength of ICCs can indicate grouping effects in the data, thus providing another way to evaluate the (non)independence of data. ICCs for reported perceived interaction goals, including stigma communication, and the set of dependent variables are displayed in Tables 4.5 and 4.6, respectively. Again, with the exception of statistically significant ICCs for total perceptions of the goal to avoid (ICC = .43, $p < .05$) and reports of clinical help-seeking attitudes (ICC = .36, $p < .05$), all other ICCs were weak or non-existent, confirming that most data in this set should be treated as independent.

Table 4.5: Intraclass Correlations for Total Reported Perceived Interaction Goals and Stigma Communication for Parents and YAs (IVs)

| Outcome | Intraclass correlation |
|---|---|
| Attention to positive face | .00[+] |
| Attention to negative face | .13 |
| Attention to relationship | .03 |
| Goal to avoid | .43* |
| Goal to provide support | .004 |
| Goal to influence | .06 |
| Use of stigma communication | .23 |

[+]Intraclass correlations for these variables were so low that they could not be computed, indicating that the ICCs for these variables were near 0.
* $p < .05$

Table 4.6: Intraclass Correlations for Reported Dependent Variables

| Outcome | Intraclass correlation |
|---|---|
| Conversation satisfaction | .25 |
| Clinical help-seeking attitudes | .36* |
| Communication apprehension | .21 |
| Relational distancing | .00[+] |
| Non-clinical help-seeking attitudes | .24 |

[+]Intraclass correlations for these variables were so low that they could not be computed, indicating that the ICCs for these variables were near 0.
* $p < .05$

Finally, as an initial exploration, zero-order correlations were calculated to examine the relationships among perceived interaction goals and dependent variables as they correspond with each set of hypotheses. The first set of tables (Tables 4.7 and 4.8, respectively) present associations between total YA perceived interaction goals and parent and YA reports of communication apprehension (CA; $H2a_{i\text{-}vi}$ & $H5a_{ii}$) and total parent perceived interaction goals

and parent and YA reports of CA ($H2b_{i\text{-}vi}$ & $H5b_{ii}$). Following this, two tables corresponding to $H3a_{i\text{-}vi}$ and $H5a_{iii}$ and then $H3b_{i\text{-}vi}$ and $H5b_{iii}$ present correlations between total YA perceived interaction goals and parent and YA reports of relational distancing (Table 4.9) and total parent perceived interaction goals and parent and YA reports of relational distancing (Table 4.10). Tables 4.11 and 4.12, then, display associations between total YA perceived interaction goals and parent and YA reports of conversation satisfaction ($H4a_{i\text{-}vi}$ & $H5a_{iv}$) and total parent perceived interaction goals and parent and YA reports of conversation satisfaction ($H4b_{i\text{-}vi}$ & $H5b_{iv}$). The next table (4.13) corresponds to $H5a_{i}$. It presents correlations between total YA perceptions of interaction goals and total YA perceptions of stigma communication. The subsequent table (4.14) corresponds to $H5b_{i}$ and displays correlations between total parent perceptions of interaction goals and total parent perceptions of stigma communication. Next, Table 4.15 presents associations between total YA perceptions of interaction goals and parent and YA reports of clinical and non-clinical help-seeking attitudes ($H6a_{i\text{-}vi}$ & $H5a_{v}$). Finally, the last table in this section (Table 4.16) provides correlations for total parent perceptions of interaction goals and parent and YA reports of clinical and non-clinical help-seeking attitudes ($H6b_{i\text{-}vi}$ & $H5b_{v}$). These preliminary analyses indicated support for a number of the associations predicted by the hypotheses, most of which go on to examine the predictive nature of these relationships.

Table 4.7: Correlations Among Total YA Perceptions of Interaction Goals, Parent Communication Apprehension, and YA Communication Apprehension ($H2a_i$ – $H2a_{vi}$ & $H5a_{ii}$)

| YA Total Perceived Interaction Goal | Communication Apprehension | |
|---|---|---|
| | Parent Report | YA Report |
| Attention to positive face | -.12 | -.30* |
| Attention to negative face | -.11 | -.24 |
| Attention to relationship | -.15 | -.10 |
| Goal to avoid | .35* | .36* |
| Goal to support | -.15 | -.32* |
| Goal to influence | -.03 | .36* |
| Stigma communication | .12 | .35* |

* $p < .05$

Table 4.8: Correlations Among Total Parent Perceptions of Interaction Goals, Parent Communication Apprehension, and YA Communication Apprehension ($H2b_i$ – $H2b_{vi}$ & $H5b_{ii}$)

| Parent Total Perceived Interaction Goal | Communication Apprehension | |
|---|---|---|
| | Parent Report | YA Report |
| Attention to positive face | -.47** | -.15 |
| Attention to negative face | -.26 | -.29* |
| Attention to relationship | -.04 | -.13 |
| Goal to avoid | .66** | .32* |
| Goal to support | -.26 | -.20 |
| Goal to influence | .35* | -.03 |
| Stigma communication | .54** | .25 |

* $p < .05$, ** $p < .01$

Table 4.9: Correlations Among Total YA Perceptions of Interaction Goals, Parent Relational Distancing, and YA Relational Distancing ($H3a_i$ – $H3a_{vi}$ & $H5a_{iii}$)

| | Relational Distancing | |
|---|---|---|
| YA Total Perceived Interaction Goal | Parent Report | YA Report |
| Attention to positive face | -.10 | -.14 |
| Attention to negative face | -.31* | -.05 |
| Attention to relationship | -.24 | -.02 |
| Goal to avoid | .53** | .41** |
| Goal to support | -.01 | -.32* |
| Goal to influence | .16 | .07 |
| Stigma communication | .37* | .21 |

* $p < .05$, ** $p < .01$

Table 4.10: Correlations Among Total Parent Perceptions of Interaction Goals, Parent Relational Distancing, and YA Relational Distancing ($H3b_i$ – $H3b_{vi}$ & $H5b_{iii}$)

| | Relational Distancing | |
|---|---|---|
| Parent Total Perceived Interaction Goal | Parent Report | YA Report |
| Attention to positive face | -.45** | -.25 |
| Attention to negative face | -.38** | -.21 |
| Attention to relationship | -.11 | -.32* |
| Goal to avoid | .74** | .24 |
| Goal to support | -.42** | -.23 |
| Goal to influence | .28* | -.10 |
| Stigma communication | .56** | .29* |

* $p < .05$, ** $p < .01$

Table 4.11: Correlations Among Total YA Perceptions of Interaction Goals, Parent Conversation Satisfaction, and YA Conversation Satisfaction ($H4a_i$ – $H4a_{vi}$ & $H5a_{iv}$)

| | Conversation Satisfaction | |
|---|---|---|
| YA Total Perceived Interaction Goal | Parent Report | YA Report |
| Attention to positive face | -.13 | .50** |
| Attention to negative face | -.05 | .28* |
| Attention to relationship | .13 | .24 |
| Goal to avoid | -.25 | -.44** |
| Goal to support | -.12 | .54** |
| Goal to influence | .20 | .08 |
| Stigma communication | .05 | -.27* |

* $p < .05$, ** $p < .01$

Table 4.12: Correlations Among Total Parent Perceptions of Interaction Goals, Parent Conversation Satisfaction, and YA Conversation Satisfaction ($H4b_i$ – $H4b_{vi}$ & $H5b_{iv}$)

| | Conversation Satisfaction | |
|---|---|---|
| Parent Total Perceived Interaction Goal | Parent Report | YA Report |
| Attention to positive face | .46** | .25 |
| Attention to negative face | .26 | .20 |
| Attention to relationship | .21 | .25 |
| Goal to avoid | -.66** | -.34* |
| Goal to support | .27* | .19 |
| Goal to influence | -.14 | -.07 |
| Stigma communication | -.52** | -.31* |

* $p < .05$, ** $p < .01$

Table 4.13: Correlations Between Total YA Perceptions of Interaction Goals and YA Reports of Stigma Communication ($H5a_i$)

| Total YA Perceived Interaction Goal | Total YA Perceived Stigma Communication |
|---|---|
| Attention to positive face | -.35* |
| Attention to negative face | -.53** |
| Attention to relationship | -.10 |
| Goal to avoid | .64** |
| Goal to support | -.17 |
| Goal to influence | .36* |

* $p < .05$, ** $p < .01$

Table 4.14: Correlations Between Total Parent Perceptions of Interaction Goals and Parent Reports of Stigma Communication ($H5b_i$)

| Total Parent Perceived Interaction Goal | Total Parent Perceived Stigma Communication |
|---|---|
| Attention to positive face | -.18 |
| Attention to negative face | -.15 |
| Attention to relationship | .03 |
| Goal to avoid | .89** |
| Goal to support | -.14 |
| Goal to influence | .21 |

* $p < .05$, ** $p < .01$

Table 4.15: Correlations Among Total YA Perceptions of Interaction Goals, Parent Clinical and Non-Clinical Help-Seeking Attitudes, and YA Clinical and Non-Clinical Help-Seeking Attitudes ($H6a_i$ – $H6a_{vi}$ & $H5a_v$)

| YA Total Perceived Interaction Goal | Clinical Help-Seeking Attitudes | | Non-Clinical Help-Seeking Attitudes | |
|---|---|---|---|---|
| | Parent Report | YA Report | Parent Report | YA Report |
| Attention to positive face | -.00 | .26 | .21 | .02 |
| Attention to negative face | .11 | .19 | .27* | -.15 |
| Attention to relationship | .04 | -.08 | -.05 | -.05 |
| Goal to avoid | -.34* | -.43** | -.19 | .10 |
| Goal to support | -.05 | .10 | .02 | .09 |
| Goal to influence | -.10 | -.18 | -.17 | .12 |
| Stigma communication | -.30* | -.60* | -.34* | .08 |

* $p < .05$, ** $p < .01$

Table 4.16: Correlations Among Total Parent Perceptions of Interaction Goals, Parent Clinical and Non-Clinical Help-Seeking Attitudes, and YA Clinical and Non-Clinical Help-Seeking Attitudes ($H6a_i$ – $H6a_{vi}$ & $H5b_v$)

| Parent Total Perceived Interaction Goal | Clinical Help-Seeking Attitudes | | Non-Clinical Help-Seeking Attitudes | |
|---|---|---|---|---|
| | Parent Report | YA Report | Parent Report | YA Report |
| Attention to positive face | .38** | .23 | .16 | .09 |
| Attention to negative face | .35* | .33* | .36* | .13 |
| Attention to relationship | .04 | .14 | -.06 | .15 |
| Goal to avoid | -.47** | -.31* | -.31* | -.06 |
| Goal to support | .31* | .29* | .11 | -.07 |
| Goal to influence | -.31* | -.18 | -.07 | .10 |
| Stigma communication | -.40** | -.23 | -.24 | -.02 |

* $p < .05$, ** $p < .01$

## PRIMARY ANALYSES

Given that participants were nested within familial dyads, data were expected to be dependent; however, preliminary correlation analyses provided evidence indicating that the majority of data points were, in fact, independent. Therefore, with the exception of hypotheses related to the goal to avoid variable (when treated as a dependent variable) and the clinical help-seeking attitudes dependent variable, which both demonstrated evidence of data dependence, general linear model (GLM) multivariate regression analyses were conducted to test hypotheses (Warner, 2013). GLM multivariate regression analysis allows for models with multiple dependent variables by one or more predictor variables specified as covariates (Warner, 2013). This analytic procedure is appropriate for categorical or continuous dependent and independent variables.

Additionally, since there was correlational evidence of data dependence for two dependent variables of interest to this study (i.e., the goal to avoid and clinical help-seeking attitudes), multilevel linear modeling (MLM) using a restricted maximum likelihood estimation (REML) method was used to test hypotheses related to those dependent variables while accounting for the nested nature of the data (Hox, 2010; Kenny et al., 2006; Snijders & Bosker, 1999). REML accounts for smaller data sets by adding bias correction terms to the maximum likelihood estimates, which produces less biased estimates when a sample size is smaller than 50 (Bryk & Raudenbush, 1992; Hox & Kreft, 1994; Snijders & Bosker, 1999). MLM results are displayed following GLM multivariate regression results. First, however, correlations testing the first set of hypotheses are presented.

### Correlations

To test the first set of hypotheses put forth in this study, correlations were calculated. These hypotheses posited that YA perceptions of parent interaction goals and use of stigma communication would be positively correlated with parent perceptions of their own interaction goals and stigma communication. These hypotheses also proposed that parent perceptions of YA

interaction goals and use of stigma communication would be positively correlated with YA perceptions of their own interaction goals and use of stigma communication. Correlations between YA perceptions of parent interaction goals and use of stigma communication and parent perceptions of their own interaction goals and use of stigma communication ($H1a_{i\text{-}vi}$) are displayed in Table 4.17. Parent perceptions of YA interaction goals and use of stigma communication and YA perceptions of their own interaction goals and use of stigma communication ($H1b_{i\text{-}vi}$) are presented in Table 4.18.

Results indicated weak or non-existent correlations between parent perceptions of their own interaction goals and YA perceptions of parent's interaction goals, including the use of stigma communication. There was, however, evidence suggesting that YA perceptions of their own goal to avoid was significantly correlated with parent perceptions of YA's goal to avoid ($r$ = .43, $p < .01$). Results also demonstrated that YA perceptions of their own use of stigma communication was significantly related to parent perceptions of YA use of stigma communication ($r$ = .38, $p < .05$). In sum, these results did not support $H1a_{i\text{-}vi}$, but there was support for $H1b_{iv}$ *and* $H1b_{vi}$. These significant correlations indicated that for YAs' goal to avoid and YAs' use of stigma communication, parent perceptions and YA perceptions of aligned with one another.

Table 4.17: Correlations Among YA Perceptions of Parent Interaction Goals and Parent Perceptions of Their Own Interaction Goals (H1ai – H1avi)

| YA Perception of Parent Interaction Goals | Parent Perception of Own Interaction Goals |
|---|---|
| Attention to positive face | .17 |
| Attention to negative face | .06 |
| Attention to relationship | .06 |
| Goal to avoid | .28 |
| Goal to support | .11 |
| Goal to influence | .15 |
| Use of stigma communication | .05 |

Table 4.18: Correlations Among Parent Perceptions of YA Interaction Goals and YA Perceptions of Their Own Interaction Goals ($H1b_i$ – $H1b_{vi}$)

| Parent Perception of YA Interaction Goals | YA Perception of Own Interaction Goals |
|---|---|
| Attention to positive face | -.00 |
| Attention to negative face | .27 |
| Attention to relationship | .006 |
| Goal to avoid | .43** |
| Goal to support | .07 |
| Goal to influence | .09 |
| Use of stigma communication | .38* |

* $p < .05$, ** $p < .01$

**GLM multivariate regressions**

The first set of hypotheses (*H2a-H4b*, *H6a-H6b*) posited associations between perceptions of own and partner interaction goals and own and partner reports of individual and relational outcomes (i.e., communication apprehension, relational distancing, conversation satisfaction, clinical help-seeking attitudes, and non-clinical help-seeking attitudes). The next set of hypotheses (*H5a-H5b*) dealt with associations between perceptions of own and partner use of stigma communication and perceptions of own and partner attention to interaction goals as well as associations between perceptions of own and partner use of stigma communication and own and partner reports of individual and relational outcomes. For consistency, results of the GLM multivariate regression analyses are presented in numerical order. However, before regression results are summarized for each set of hypotheses, multivariate test results for all tested GLM multivariate regression models are displayed for descriptive purposes in Tables 4.19 – 4.21.

Table 4.19: Multivariate Test Results for General Linear Model Multivariate Regression Analyses with Total Parent and YA Perceptions of Stigma Communication (separate IVs) and Total Parent and YA Perceptions of Goals (separate DVs)

| Model | Wilks' Λ | *F* | *p* | $\eta_p^2$ |
|---|---|---|---|---|
| Total Parent Perceptions of Stigma Communication | .12 | 15.47 | <.001 | .88 |
| Total YA Perceptions of Stigma Communication | .31 | 4.87 | <.001 | .69 |

Table 4.20: Multivariate Test Results for All General Linear Model Multivariate Regression Analyses with Total Parent Perceptions of Goals and Stigma Communication (IVs) and Parent and YA DVs

| Model | Wilks' Λ | *F* | *p* | $\eta_p^2$ |
|---|---|---|---|---|
| Total Parent Perceptions of Positive Face (IV) | | | | |
| Parent & YA CA (DVs) | .78 | 5.12 | .01 | .22 |
| Parent & YA relational distancing (DVs) | .73 | 6.65 | .003 | .27 |
| Parent & YA conversation satisfaction (DVs) | .77 | 5.42 | .009 | .23 |
| Parent & YA clinical help-seeking attitudes (DVs) | .84 | 3.34 | .05 | .16 |
| Parent & YA non-clinical help-seeking attitudes (DVs) | .97 | .50 | .61 | .03 |
| Total Parent Perceptions of Negative Face (IV) | | | | |
| Parent & YA CA | .88 | 2.57 | .09 | .13 |
| Parent & YA relational distancing | .81 | 4.31 | .02 | .19 |
| Parent & YA conversation satisfaction | .91 | 1.77 | .19 | .09 |
| Parent & YA clinical help-seeking attitudes | .83 | 3.60 | .04 | .17 |
| Parent & YA non-clinical help-seeking attitudes | .87 | 2.70 | .08 | .13 |
| Total Parent Perceptions of Relational Maintenance (IV) | | | | |
| Parent & YA CA | .98 | .31 | .73 | .02 |
| Parent & YA relational distancing | .89 | 2.33 | .11 | .11 |
| Parent & YA conversation satisfaction | .92 | 1.65 | .21 | .08 |
| Parent & YA clinical help-seeking attitudes | .98 | .34 | .72 | .02 |
| Parent & YA non-clinical help-seeking attitudes | .97 | .61 | .55 | .03 |
| Total Parent Perceptions of Goal to Avoid (IV) | | | | |
| Parent & YA CA | .54 | 15.40 | <.001 | .46 |
| Parent & YA relational distancing | .39 | 28.73 | <.001 | .62 |
| Parent & YA conversation satisfaction | .53 | 15.84 | <.001 | .47 |
| Parent & YA clinical help-seeking attitudes | .76 | 5.85 | .006 | .25 |
| Parent & YA non-clinical help-seeking attitudes | .90 | 2.00 | .15 | .10 |
| Total Parent Perceptions of Goal to Support (IV) | | | | |
| Parent & YA CA | .91 | 1.75 | .19 | .09 |
| Parent & YA relational distancing | .77 | 5.25 | .01 | .23 |
| Parent & YA conversation satisfaction | .91 | 1.72 | .19 | .09 |
| Parent & YA clinical help-seeking attitudes | .87 | 2.71 | .08 | .13 |
| Parent & YA non-clinical help-seeking attitudes | .98 | .39 | .68 | .02 |
| Total Parent Perceptions of Goal to Influence (IV) | | | | |
| Parent & YA CA | .87 | 2.82 | .07 | .14 |
| Parent & YA relational distancing | .91 | 1.69 | .20 | .09 |
| Parent & YA conversation satisfaction | .98 | .38 | .68 | .02 |
| Parent & YA clinical help-seeking attitudes | .90 | 2.10 | .14 | .11 |
| Parent & YA non-clinical help-seeking attitudes | .98 | .35 | .70 | .02 |
| Total Parent Perceptions of Stigma Communication (IV) | | | | |
| Parent & YA CA | .70 | 7.78 | .002 | .30 |
| Parent & YA relational distancing | .60 | 12.01 | <.001 | .40 |
| Parent & YA conversation satisfaction | .70 | 7.84 | .001 | .30 |
| Parent & YA clinical help-seeking attitudes | .83 | 3.64 | .04 | .17 |
| Parent & YA non-clinical help-seeking attitudes | .94 | 1.15 | .33 | .06 |

Table 4.21: Multivariate Test Results for All General Linear Model Multivariate Regression Analyses with Total YA Perceptions of Goals and Stigma Communication (IVs) and Parent and YA DVs

| Model | Wilks' Λ | *F* | *p* | $\eta_p^2$ |
|---|---|---|---|---|
| Total YA Perceptions of Positive Face (IV) | | | | |
| Parent & YA CA (DVs) | .91 | 1.82 | .18 | .09 |
| Parent & YA relational distancing (DVs) | .97 | .56 | .58 | .03 |
| Parent & YA conversation satisfaction (DVs) | .69 | 8.26 | .001 | .32 |
| Parent & YA clinical help-seeking attitudes (DVs) | .92 | 1.54 | .23 | .08 |
| Parent & YA non-clinical help-seeking attitudes (DVs) | .95 | .89 | .42 | .05 |
| Total YA Perceptions of Negative Face (IV) | | | | |
| Parent & YA CA | .94 | 1.17 | .32 | .06 |
| Parent & YA relational distancing | .90 | 1.92 | .16 | .10 |
| Parent & YA conversation satisfaction | .91 | 1.84 | .17 | .09 |
| Parent & YA clinical help-seeking attitudes | .96 | .71 | .50 | .04 |
| Parent & YA non-clinical help-seeking attitudes | .87 | 2.73 | .08 | .13 |
| Total YA Perceptions of Relational Maintenance (IV) | | | | |
| Parent & YA CA | .97 | .50 | .61 | .03 |
| Parent & YA relational distancing | .94 | 1.15 | .33 | .06 |
| Parent & YA conversation satisfaction | .94 | 1.24 | .30 | .07 |
| Parent & YA clinical help-seeking attitudes | .99 | .22 | .80 | .01 |
| Parent & YA non-clinical help-seeking attitudes | .99 | .07 | .93 | .00 |
| Total YA Perceptions of Goal to Avoid (IV) | | | | |
| Parent & YA CA | .80 | 4.55 | .02 | .20 |
| Parent & YA relational distancing | .54 | 15.22 | <.001 | .46 |
| Parent & YA conversation satisfaction | .79 | 4.78 | .01 | .21 |
| Parent & YA clinical help-seeking attitudes | .77 | 5.25 | .01 | .23 |
| Parent & YA non-clinical help-seeking attitudes | .94 | 1.13 | .34 | .06 |
| Total YA Perceptions of Goal to Support (IV) | | | | |
| Parent & YA CA | .89 | 2.20 | .13 | .11 |
| Parent & YA relational distancing | .90 | 2.03 | .15 | .10 |
| Parent & YA conversation satisfaction | .64 | 10.08 | <.001 | .36 |
| Parent & YA clinical help-seeking attitudes | .98 | .37 | .69 | .02 |
| Parent & YA non-clinical help-seeking attitudes | .99 | .15 | .86 | .01 |
| Total YA Perceptions of Goal to Influence (IV) | | | | |
| Parent & YA CA | .85 | 3.08 | .05 | .15 |
| Parent & YA relational distancing | .97 | .57 | .57 | .03 |
| Parent & YA conversation satisfaction | .96 | .77 | .47 | .04 |
| Parent & YA clinical help-seeking attitudes | .97 | .65 | .53 | .04 |
| Parent & YA non-clinical help-seeking attitudes | .94 | 1.11 | .34 | .06 |
| Total YA Perceptions of Stigma Communication (IV) | | | | |
| Parent & YA CA | .87 | 2.59 | .09 | .13 |
| Parent & YA relational distancing | .82 | 3.87 | .03 | .18 |
| Parent & YA conversation satisfaction | .91 | 1.73 | .19 | .09 |
| Parent & YA clinical help-seeking attitudes | .63 | 10.51 | <.001 | .37 |
| Parent & YA non-clinical help-seeking attitudes | .85 | 3.19 | .05 | .15 |

### *Regression Models for Communication Apprehension*

#### *$H2a_i$-$H2a_{vi}$: YA Perceptions of Goals (IV) and Communication Apprehension (DV)*

According to the first half of the second set of hypotheses, YA perceptions of their own and their partner's interaction goals predict their own and their partner's communication apprehension (CA). Specifically, separate hypotheses for each interaction goal posited that total YA perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would individually be negatively associated with parent and YA CA, while the separate goals of avoiding and influencing would positively predict parent and YA CA. Results related to total YA perceptions of each individual interaction goal are presented in Table 4.22.

There was no evidence that YA perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly predicted parent CA ($\beta$ = -.10, $t$ = -.76, $p$ = .45) or YA CA ($\beta$ = -.31, $t$ = -1.90, $p$ = .07). There also was no evidence that YA perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly predicted parent CA ($\beta$ = -.13, $t$ = -.64, $p$ = .52) or YA CA ($\beta$ = -.37, $t$ = -1.52, $p$ = .14). Results provided no evidence suggesting that YA perceptions of their own and their partner's attention to relational maintenance significantly predicted parent CA ($\beta$ = -.09, $t$ = -.92, $p$ = .36) or YA CA ($\beta$ = -.08, $t$ = -.64, $p$ = .53).

Results indicated a significant, positive association between YA perceptions of their own and their partner's goal to avoid during conversations about mental health and parent CA ($\beta$ = .41, $t$ = 2.26, $p$ = .03). That is, for every one-unit increase in YA perceptions of avoidance during conversations about mental health, there was a .41-unit increase in parent reports of CA. YA perceptions of the goal to avoid during parent-YA conversations about mental health accounted for 12.1% of the variance in parent CA. Similarly, YA perceptions of their own and their partner's goal to avoid during conversations about mental health significantly, positively predicted YA CA ($\beta$ = .52, $t$ = 2.36, $p$ = .02), such that for each one-unit increase in YA

perceptions of avoidance during conversations about mental health, there was a .52-unit increase in YA reports of CA. YA perceptions of the goal to avoid during parent-YA conversations about mental health accounted for 13.1% of the variance in YA CA.

There was no evidence that YA perceptions of their own and their partner's goal to provide support during conversations about mental health significantly predicted parent CA ($\beta$ = -.12, $t$ = -.95, $p$ = .35). There was, however, evidence that YA perceptions of their own and their partner's goal to provide support significantly, inversely predicted YA CA ($\beta$ = -.31, $t$ = -2.06, $p$ = .05). That is, for each one-unit increase in YA perceptions of the goal to support during conversations about mental health, there was a -.31-unit decrease in YA reports of CA. YA perceptions of the goal to support accounted for 10.3% of the variance in YA CA. There was no evidence that YA perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent CA ($\beta$ = -.02, $t$ = -.19, $p$ = .85). Separately, results suggested that YA perceptions of their own and their partner's goal to influence significantly, positively predicted YA CA ($\beta$ = .27, $t$ = 2.36, $p$ = .03). That is, for each one-unit increase in YA perceptions of influencing during conversations about mental health, there was a .27-unit increase in YA reports of CA. YA perceptions of the goal to influence accounted for 13.1% of the variance in YA CA.

To summarize, there was evidence that YA perceptions of their own and their parent's attention to the goal to avoid during conversations about mental health positively predicted parent and YA CA. This finding provides support for $H2a_{iv}$. Additionally, results indicated that YA perceptions of their own and their parent's attention to the task goals to support and to influence negatively and positively predicted YA CA, respectively, but did not predict parent CA. These findings provide partial support for $H2a_{v}$ and $H2a_{vi}$.

Table 4.22: Results of General Linear Model Multivariate Regression Analyses for $H2a_i$-$H2a_{vi}$

| YA Total Perceived Goal | YA-reported communication apprehension | | | | Parent-reported communication apprehension | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | -1.90 | -.31 | [-.64, .02] | .09 | -.76 | -.10 | [-.38, .17] | .02 |
| Attention to negative face | -1.52 | -.38 | [-.86, .12] | .06 | -.64 | -.13 | [-.54, .28] | .01 |
| Attention to the relationship | -.64 | -.08 | [-.34, .18] | .01 | -.92 | -.09 | [-.30, .11] | .02 |
| Avoidance | 2.36** | .52 | [.07, .97] | .13 | 2.25* | .41 | [.04, .78] | .12 |
| Support | -2.06* | -.31 | [-.61, -.01] | .10 | -.95 | -.12 | [-.37, .14] | .02 |
| Influence | 2.36* | .27 | [.04, .50] | .13 | -.19 | -.02 | [-.22, .18] | .00 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$

### *$H2b_i$-$2b_{vi}$: Parent Perceptions of Goals (IV) and Communication Apprehension (DV)*

According to the second half of the second set of hypotheses, parent perceptions of their own and their partner's interaction goals predict their own and their partner's CA. Specifically, separate hypotheses for each interaction goal posited that total parent perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would be negatively associated with parent and YA CA, while the separate goals of avoiding and influencing would be positively associated with parent and YA CA. Results related to total parent perceptions of each individual interaction goal are presented in Table 4.23.

Results indicated a significant, inverse association between parent perceptions of their own and their partner's affirmation of positive face during conversations about mental health and parent CA ($\beta = -.38$, $t = -3.23$, $p = .003$). That is, for each one-unit increase in parent perceptions of affirming positive face during conversations about mental health, there was a -.38-unit decrease in parent reports of CA. Parent perceptions of affirming positive face accounted for 22% of the variance in parent CA. Parent perceptions of affirming positive face did not,

however, significantly predict YA CA ($\beta$ = -.15, $t$ = -.94, $p$ = .36). There was no evidence that parent perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly predicted parent CA ($\beta$ = -.25, $t$ = -1.66, $p$ = .11) or YA CA ($\beta$ = -.34, $t$ = -1.87, $p$ = .07). There was no evidence that parent perceptions of their own and their partner's attention to the goal of relational maintenance significantly predicted parent CA ($\beta$ = -.03, $t$ = -.25, $p$ = .80) or YA CA ($\beta$ = -.10, $t$ = -.80, $p$ = .43).

Results indicated a significant, positive association between parent perceptions of their own and their partner's goal to avoid during conversations about mental health and parent CA ($\beta$ = .64, $t$ = 5.32, $p$ < .001). That is, for each one-unit increase in parent perceptions of avoidance during conversations about mental health, there was a .64-unit increase in parent reports of CA. Parent perceptions of the goal to avoid accounted for 43% of the variance in parent CA. Similarly, parent perceptions of their own and their partner's goal to avoid during conversations about mental health significantly, positively predicted YA CA ($\beta$ = .39, $t$ = 2.08, $p$ = .05), such that for each one-unit increase in parent perceptions of avoidance during conversations about mental health, there was a .39-unit increase in YA reports of CA. Parent perceptions of the goal to avoid accounted for 10.5% of the variance in YA CA.

There was no evidence that parent perceptions of their own and their partner's goal to provide support during conversations about mental health significantly predicted parent CA ($\beta$ = -.18, $t$ = -1.64, $p$ = .11) or YA CA ($\beta$ = -.17, $t$ = -1.26, $p$ = .22). Results indicated a significant, positive association between parent perceptions of their own and their partner's goal to influence and parent CA ($\beta$ = .22, $t$ = 2.25, $p$ = .03). That is, for each one-unit increase in parent perceptions of the goal to influence, there was a .22-unit increase in parent reports of CA. Parent perceptions of the goal to influence accounted for 12% of the variance in parent CA as it related to parent-YA conversations about mental health. However, parent perceptions of the goal to influence did not significantly predict YA CA ($\beta$ = -.03, $t$ = -.20, $p$ = .84).

To summarize, there was evidence that parent perceptions of their own and their YA's attention to the goal to avoid during conversations about mental health positively predicted

parent and YA CA. This finding provides support for *H2b*$_{iv}$. Additionally, results indicated that parent perceptions of their own and their YA's attention to affirming positive face and the goal to influence negatively and positively predicted parent CA, respectively, but did not predict YA CA. These findings provide partial support for *H2b*$_{i}$ and *H2b*$_{v}$.

Table 4.23: Results of General Linear Model Multivariate Regression Analyses for H2b$_{i}$-H2b$_{vi}$

| Parent Total Perceived Goal | YA-reported communication apprehension | | | | Parent-reported communication apprehension | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | -.94 | -.15 | [-.49, .18] | .02 | -3.23** | -.38 | [-.62, -.14] | .22 |
| Attention to negative face | -1.87 | -.34 | [-.70, .03] | .09 | -1.66 | -.25 | [-.55, .06] | .07 |
| Attention to the relationship | -.80 | -.10 | [-.35, .15] | .02 | -.25 | -.03 | [-.23, .18] | .00 |
| Avoidance | 2.08* | .39 | [.01, .76] | .11 | 5.32*** | .64 | [.40, .88] | .43 |
| Support | -1.26 | -.17 | [-.45, .11] | .04 | -1.64 | -.18 | [-.40, .04] | .07 |
| Influence | -.20 | -.03 | [-.29, .23] | .00 | 2.25* | .22 | [.02, .42] | .12 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

### *Regression Models for Relational Distancing*

#### *H3a$_{i}$-H3a$_{vi}$: YA Perceptions of Goals (IV) and Relational Distancing (DV)*

According to the first half of the third set of hypotheses, YA perceptions of their own and their partner's interaction goals predict their own and their partner's relational distancing. Specifically, separate hypotheses for each interaction goal posited that total YA perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would be negatively associated with parent and YA relational distancing, while the separate goals of avoiding and influencing would be positively associated

with parent and YA relational distancing. Results related to total YA perceptions of each individual interaction goal are presented in Table 4.24.

There was no evidence that YA perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly predicted parent reports of relational distancing ($\beta$ = -.20, $t$ = -.59, $p$ = .56) or YA reports of relational distancing ($\beta$ = -.19, $t$ = -.88, $p$ = .39). There also was no evidence that YA perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly predicted parent perceptions of relational distancing ($\beta$ = -.93, $t$ = -1.96, $p$ = .06) or YA relational distancing ($\beta$ = -.10, $t$ = -.30, $p$ = .77). Similarly, there was no evidence that YA perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly predicted parent perceptions of relational distancing ($\beta$ = -.38, $t$ = -1.53, $p$ = .14) or YA perceptions of relational distancing ($\beta$ = -.02, $t$ = -.13, $p$ = .90).

Results did however suggest a significant, positive association between YA perceptions of their own and their partner's goal to avoid during conversations about mental health and parent perceptions of relational distancing ($\beta$ = 1.53, $t$ = 3.81, $p$ = .001). That is, for each one-unit increase in YA perceptions of avoidance during conversations about mental health, there was a 1.53-unit increase in parent reports of relational distancing. YA perceptions of the goal to avoid during parent-YA conversations about mental health accounted for 28.1% of the variance in parent reports of relational distancing. Following the same pattern, YA perceptions of their own and their partner's goal to avoid significantly, positively predicted YA reports of relational distancing ($\beta$ = .79, $t$ = 2.76, $p$ = .01), such that for each one-unit increase in YA perceptions of the goal to avoid during conversations about mental health, there was a .79-unit increase in YA reports of relational distancing. YA perceptions of the goal to avoid accounted for 17.1% of the variance in YA reports of relational distancing.

There was no evidence that YA perceptions of their own and their partner's goal to provide support during conversations about mental health significantly predicted parent perceptions of relational distancing ($\beta$ = -.02, $t$ = -.06, $p$ = .95). There was, however, evidence

that YA perceptions of their own and their partner's attention to the support goal significantly, inversely predicted YA perceptions of relational distancing ($\beta$ = -.40, $t$ = -2.04, $p$ = .05). That is, for each one-unit increase in YA perceptions of the goal to support, there was a -.40-unit decrease in YA perceptions of relational distancing between YAs and the parent with whom they engaged in the mental heal conversation. YA perceptions of the goal to provide support accounted for 10.1% of the variance in YA reports of relational distancing. There was no evidence that YA perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent perceptions of relational distancing ($\beta$ = .24, $t$ = .99, $p$ = .33) or YA perceptions of relational distancing ($\beta$ = .07, $t$ = .41, $p$ = .68).

To summarize, there was evidence that YA perceptions of their own and their parent's attention to the goal to avoid during conversations about mental health positively predicted parent and YA perceptions of relational distancing. This finding provides support for $H3a_{iv}$. Additionally, results indicated that YA perceptions of their own and their parent's attention to the task goal to support negatively predicted YA perceptions of relational distancing, but did not predict parent perceptions of relational distancing. This finding provides partial support for $H3a_{v}$.

Table 4.24: Results of General Linear Model Multivariate Regression Analyses for $H3a_i$-$H3a_{vi}$

| YA Total Perceived Goal | YA-reported relational distancing | | | | Parent-reported relational distancing | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | -.88 | -.19 | [-.64, .26] | .02 | -.59 | -.20 | [-.88, .48] | .01 |
| Attention to negative face | -.30 | -.10 | [-.77, .57] | .00 | -1.96 | -.93 | [-1.88, .03] | .09 |
| Attention to the relationship | -.13 | -.02 | [-.36, .32] | .00 | -1.53 | -.38 | [-.87, .12] | .06 |
| Avoidance | 2.76** | .79 | [.21, 1.37] | .17 | 3.81** | 1.53 | [.71, 2.34] | .28 |
| Support | -2.04* | -.40 | [-.80, -.003] | .10 | -.06 | -.02 | [-.65, .61] | .00 |
| Influence | .41 | .07 | [-.26, .39] | .01 | .99 | .24 | [-.25, .72] | .03 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$

### *$H3b_i$-$H3b_{vi}$: Parent Perceptions of Goals (IV) and Relational Distancing (DV)*

According to the second half of the third set of hypotheses, parent perceptions of their own and their partner's interaction goals predict their own and their partner's relational distancing. Specifically, separate hypotheses for each interaction goal posited that total parent perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would be negatively associated with parent and YA relational distancing, while the separate goals of avoiding and influencing would be positively associated with parent and YA relational distancing. Results related to total parent perceptions of each individual interaction goal are presented in Table 4.25.

Results indicated that parent perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly, inversely predicted parent perceptions of relational distancing ($\beta$ = -.91, $t$ = -3.09, $p$ = .004). That is, for each one-unit increase in parent perceptions of affirming positive face during conversations about mental health, there was a -.91-unit decrease in parent perceptions of relational distancing between themselves and the YA child with whom they engaged in the mental health conversation. Parent

perceptions of affirming positive face accounted for 20.6% of the variance in parent reports of relational distancing. Parent perceptions of affirming positive face did not, however, significantly predict YA perceptions of relational distancing ($\beta$ = -.33, $t$ = -1.55, $p$ = .13). Results also indicated that parent perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly, inversely predicted parent perceptions of relational distancing ($\beta$ = -.87, $t$ = -2.51, $p$ = .02). That is, for each one-unit increase in parent perceptions of affirming negative face during conversations about mental health, there was a -.87-unit decrease in parent perceptions of relational distancing. Parent perceptions of affirming negative face accounted for 14.6% of the variance in parent reports of relational distancing. However, parent perceptions of affirming negative face did not significantly predict YA perceptions of relational distancing ($\beta$ = -.32, $t$ = -1.33, $p$ = .19).

Parent perceptions of attention to relational maintenance did not significantly predict parent perceptions of relational distancing ($\beta$ = -.16, $t$ = -.67, $p$ = .51). However, results indicated that parent perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly, inversely predicted YA perceptions of relational distancing ($\beta$ = -.32, $t$ = -2.04, $p$ = .05), such that for each one-unit increase in parent perceptions of attention to relational maintenance during conversations about mental health, there was a -.32-unit decrease in YA perceptions of relational distancing. Parent perceptions of attention to the relationship accounted for 10.1% of the variance in YA reports of relational distancing. Results suggested that parent perceptions of their own and their partner's goal to avoid during parent-YA conversations about mental health significantly, positively predicted parent perceptions of relational distancing ($\beta$ = 1.76, $t$ = 6.76, $p$ < .001). That is, for each one-unit increase in parent perceptions of avoidance during conversations about mental health, there was a 1.76-unit increase in parent perceptions of relational distancing. Parent perceptions of the goal to avoid accounted for 55.3% of the variance in parent reports of relational distancing. However, parent perceptions of the goal to avoid did not significantly predict YA perceptions of relational distancing ($\beta$ = .37, $t$ = 1.50, $p$ = .14).

Results indicated that parent perceptions of their own and their partner's goal to provide support during parent-YA conversations about mental health significantly, inversely predicted parent perceptions of relational distancing ($\beta$ = -.71, $t$ = -2.78, $p$ = .009). For each one-unit increase in parent perceptions of the goal to support, there was a -.71-unit decrease in parent perceptions of relational distancing. Parent perceptions of the goal to support accounted for 17.2% of the variance in parent reports of relational distancing. However, parent perceptions of the goal to provide support did not significantly predict YA perceptions of relational distancing ($\beta$ = -.25, $t$ = -.41, $p$ = .17). There was no evidence that parent perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent perceptions of relational distancing ($\beta$ = .43, $t$ = 1.75, $p$ = .09) or YA perceptions of relational distancing ($\beta$ = -.10, $t$ = -.60, $p$ = .55).

To summarize, there was evidence that parent perceptions of their own and their partner's attention to affirming positive face, affirming negative face, and the goal to support separately inversely predicted parent perceptions of relational distancing with their conversation partner. This finding provides partial support for $H3b_{i}$, $H3b_{ii}$, and $H3b_{v}$. There was also partial support for $H3b_{iii}$ given evidence that parent perceptions of their own and their partner's goal to maintain the relationship inversely predicted YA perceptions of relational distancing. Lastly, there was evidence that parent perceptions of their own and their partner's goal to avoid positively predicted parent reports of relational distancing, but not YA reports of relational distancing. This finding partially supports $H3b_{iv}$.

Table 4.25: Results of General Linear Model Multivariate Regression Analyses for $H3b_i$-$H3b_{vi}$

| Parent Total Perceived Goal | YA-reported relational distancing | | | | Parent-reported relational distancing | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | -1.55 | -.33 | [-.76, .10] | .06 | -3.09** | -.91 | [-1.50, -.31] | .21 |
| Attention to negative face | -1.33 | -.33 | [-.82, .17] | .05 | -2.52* | -.87 | [-1.57, -.17] | .15 |
| Attention to the relationship | -2.04* | -.32 | [-.63, -.003] | .10 | -.67 | -.16 | [-.66, .33] | .01 |
| Avoidance | 1.50 | .38 | [-.13, .89] | .06 | 6.76*** | 1.76 | [1.24, 2.29] | .55 |
| Support | -1.41 | -.25 | [-.62, .11] | .05 | -2.78** | -.71 | [-1.22, -.19] | .17 |
| Influence | -.60 | -.10 | [-.44, .24] | .01 | 1.75 | .43 | [-.07, .92] | .08 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

### *Regression Models for Conversation Satisfaction*

#### *$H4a_i$-$H4a_{vi}$: YA Perceptions of Goals (IV) and Conversation Satisfaction (DV)*

According to the first half of the fourth set of hypotheses, YA perceptions of their own and their partner's interaction goals predict their own and their partner's conversation satisfaction. Specifically, separate hypotheses for each interaction goal posited that total YA perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would positively predict parent and YA conversation satisfaction, while the separate goals of avoiding and influencing would negatively predict parent and YA conversation satisfaction. Results related to total YA perceptions of each individual interaction goal are presented in Table 4.26.

Results indicated that YA perceptions of affirming positive face did not significantly predict parent perceptions of conversation satisfaction ($\beta = -.14$, $t = -.80$, $p = .43$). Results did, however, suggest that YA perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly, positively predicted YA conversation satisfaction ($\beta = .57$, $t = 3.48$, $p = .001$). That is, for each one-unit increase in YA

perceptions of affirming positive face, there was a .57-unit increase in YA satisfaction with the parent-YA conversation about mental health. YA perceptions of affirming positive face accounted for 24.7% of the variance in YA conversation satisfaction. There was no evidence that YA perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = -.07, $t$ = -.28, $p$ = .78) or YA conversation satisfaction ($\beta$ = .47, $t$ = 1.78, $p$ = .08).

There was no evidence that YA perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = .10, $t$ = .78, $p$ = .44) or YA conversation satisfaction ($\beta$ = .21, $t$ = 1.53, $p$ = .13). YA perceptions of the goal to avoid during conversations about mental health did not significantly predict parent perceptions of conversation satisfaction ($\beta$ = -.36, $t$ = -1.54, $p$ = .13). Results indicated that YA perceptions of their own and their partner's goal to avoid during conversations about mental health significantly, inversely predicted YA conversation satisfaction ($\beta$ = -.70, $t$ = -2.94, $p$ = .006). That is, for each one-unit increase in YA perceptions of avoidance, there was a -.70-unit decrease in YA satisfaction with the parent-YA conversation about mental health. YA perceptions of the goal to avoid accounted for 18.9% of the variance in YA conversation satisfaction.

YA perceptions of the goal to provide support during conversations about mental health did not significantly predict parent perceptions of conversation satisfaction ($\beta$ = -.12, $t$ = -.74, $p$ = .46). Results suggested that YA perceptions of their own and their partner's goal to provide support during conversations about mental health significantly, positively predicted YA conversation satisfaction ($\beta$ = .57, $t$ = 3.90, $p$ < .001), such that for each one-unit increase in YA perceptions of the goal to support during conversations about mental health, there was a .57-unit increase in YA conversation satisfaction. YA perceptions of the goal to support accounted for 29.1% of the variance in YA conversation satisfaction. There was no evidence that YA perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = .15, $t$ = 1.25, $p$ = .22) or YA

conversation satisfaction ($\beta$ = .06, $t$ = .47, $p$ = .64). An inverse association was anticipated between YA perceptions of the goal to influence and YA and parent conversation satisfaction, but results suggested a positive relationship between these variables.

To summarize, there was evidence that YA perceptions of their own and their parent's attention to the goals of affirming positive face and providing support positively predicted YA conversation satisfaction but did not predict parent conversation satisfaction. These findings provide partial support for $H4a_i$ and $H4a_v$. Additionally, there was partial support for $H4a_{iv}$ given that YA perceptions of their own and their parent's goal to avoid during conversations about mental health negatively predicted YA conversation satisfaction but did not predict parent reports of conversation satisfaction.

Table 4.26: Results of General Linear Model Multivariate Regression Analyses for $H4a_i$-$H4a_{vi}$

| YA Total Perceived Goal | YA-reported conversation satisfaction | | | | Parent-reported conversation satisfaction | | | |
|---|---|---|---|---|---|---|---|---|
| | $t$ | $\beta$ | 95% CI | $\eta_p^2$ | $t$ | $\beta$ | 95% CI | $\eta_p^2$ |
| Attention to positive face | 3.48** | .57 | [.24, .90] | .25 | -.80 | -.14 | [-.48, .21] | .02 |
| Attention to negative face | 1.78 | .47 | [-.07, 1.02] | .08 | -.28 | -.07 | [-.58, .43] | .00 |
| Attention to the relationship | 1.53 | .21 | [-.07, .50] | .06 | .78 | .10 | [-.16, .35] | .02 |
| Avoidance | -2.94** | -.70 | [-1.18, -.22] | .19 | -1.54 | -.36 | [-.82, .11] | .06 |
| Support | 3.90*** | .57 | [.28, .87] | .29 | -.74 | -.12 | [-.43, .20] | .02 |
| Influence | .47 | .06 | [-.21, .34] | .01 | 1.25 | .15 | [-.09, .39] | .04 |

*Note.* $N$ = 78. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$

### *$H4b_i$-$H4b_{vi}$: Parent Perceptions of Goals (IV) and Conversation Satisfaction (DV)*

According to the second half of the fourth set of hypotheses, parent perceptions of their own and their partner's interaction goals predict their own and their partner's conversation

satisfaction. Specifically, separate hypotheses for each interaction goal posited that total parent perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would positively predict parent and YA conversation satisfaction, while the separate goals of avoiding and influencing would negatively predict parent and YA conversation satisfaction. Results related to total parent perceptions of each individual interaction goal are presented in Table 4.27.

Results indicated that parent perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly, positively predicted parent perceptions of conversation satisfaction ($\beta$ = .46, $t$ = 3.15, $p$ = .003). That is, for each one-unit increase in parent perceptions of affirming positive face during conversations about mental health, there was a .46-unit increase in parent conversation satisfaction. Parent perceptions of affirming positive face accounted for 21.2% of the variance in parent reports of conversation satisfaction. Parent perceptions of affirming positive face did not, however, significantly predict YA perceptions of conversation satisfaction ($\beta$ = .28, $t$ = 1.56, $p$ = .13). There also was no evidence that parent perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = .30, $t$ = 1.66, $p$ = .11) or YA conversation satisfaction ($\beta$ = .26, $t$ = 1.25, $p$ = .23). There was no evidence that parent perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = .16, $t$ = 1.29, $p$ = .21) or YA conversation satisfaction ($\beta$ = .21, $t$ = 1.55, $p$ = .13).

Results suggested that parent perceptions of their own and their partner's goal to avoid during conversations about mental health significantly, inversely predicted parent perceptions of conversation satisfaction ($\beta$ = -.78, $t$ = -5.32, $p$ < .001). That is, for each one-unit increase in parent perceptions of avoidance during conversations about mental health, there was a -.78-unit decrease in parent reports of conversation satisfaction. Parent perceptions of the goal to avoid during parent-YA conversations about mental health accounted for 43.4% of the variance in

parent conversation satisfaction. Following the same pattern, parent perceptions of their own and their partner's goal to avoid significantly, inversely predicted YA perceptions of conversation satisfaction ($\beta$ = -.45, $t$ = -2.21, $p$ = .03). That is, for each one-unit increase in parent perceptions of avoidance during conversations about mental health, there was a -.45-unit decrease in YA conversation satisfaction. Parent perceptions of the goal to avoid accounted for 11.6% of the variance in YA conversation satisfaction.

There was no evidence that parent perceptions of their own and their partner's goal to provide support during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = .23, $t$ = 1.69, $p$ = .10) or YA conversation satisfaction ($\beta$ = .18, $t$ = 1.15, $p$ = .26). There also was no evidence that parent perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = -.11, $t$ = -.87, $p$ = .39) or YA conversation satisfaction ($\beta$ = -.06, $t$ = -.41, $p$ = .69).

To summarize, there was evidence that parent perceptions of their own and their partner's attention to the goals of affirming positive face positively predicted parent conversation satisfaction but did not predict YA conversation satisfaction. This finding provides partial support for $H4b_{i}$. Additionally, there was support for $H4b_{iv}$ given that parent perceptions of their own and their partner's goal to avoid during conversations about mental health negatively predicted both parent and YA conversation satisfaction.

Table 4.27: Results of General Linear Model Multivariate Regression Analyses for $H4b_i$-$H4b_{vi}$

| Parent Total Perceived Goal | YA-reported conversation satisfaction | | | | Parent-reported conversation satisfaction | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | 1.56 | .28 | [-.08, .64] | .06 | 3.15** | .46 | [.17, .76] | .21 |
| Attention to negative face | 1.25 | .26 | [-.16, .67] | .04 | 1.66 | .30 | [-.07, .67] | .07 |
| Attention to the relationship | 1.55 | .21 | [-.06, .48] | .06 | 1.29 | .16 | [-.09, .40] | .04 |
| Avoidance | -2.21* | -.45 | [-.87, -.04] | .12 | -5.32*** | -.78 | [-1.08, -.49] | .43 |
| Support | 1.15 | .18 | [-.13, .49] | .04 | 1.69 | .23 | [-.05, .50] | .07 |
| Influence | -.41 | -.06 | [-.35, .23] | .00 | -.87 | -.11 | [-.37, .15] | .02 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

### *Regression Models for Stigma Communication*

#### *H5a$_i$: YA Perceptions of Stigma Communication (IV) and Goals (DVs)*

According to hypothesis *5a$_i$*, YA perceptions of their own and their partner's use of stigma communication predict their perceptions of their own and their partner's attention to interaction goals during conversations about mental health. Specifically, it was posited that total YA perceptions of stigma communication would separately, negatively predict total YA perceptions of the goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support; whereas, total YA perceptions of stigma communication would separately, positively predict the goals of avoiding and influencing. Results related to total YA perceptions of stigma communication are presented in Table 4.28.

Results suggested that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, inversely predicted YA perceptions of their own and their partner's attention to positive face ($\beta = -.33$, $t = -2.25$, $p = .03$). That is, for each one-unit increase in YA perceptions of the use of stigma communication, there was a -.33-unit decrease in YA perceptions of the goal to affirm positive face. YA perceptions

of the use of stigma communication accounted for 12% of the variance in YA perceptions of attention to positive face.

Results suggested that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, inversely predicted YA perceptions of their own and their partner's attention to negative face ($\beta$ = -.35, $t$ = -3.82, $p$ < .001). That is, for each one-unit increase in YA perceptions of use of stigma communication during conversations about mental health, there was a -.35-unit decrease in YA perceptions of affirmation of negative face. YA perceptions of the use of stigma communication during parent-YA conversations about mental health accounted for 28.3% of the variance in YA perceptions of attention to negative face. There was no evidence that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted YA perceptions of attention to relational maintenance ($\beta$ = -.13, $t$ = -.63, $p$ = .53).

Results suggested that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, positively predicted YA perceptions of their own and their partner's goal to avoid ($\beta$ = .44, $t$ = 5.12, $p$ < .001). That is, for each one-unit increase in YA perceptions of the use of stigma communication, there was a .44-unit increase in YA perceptions of the goal to avoid. YA perceptions of the use of stigma communication accounted for 41.5% of the variance in YA perceptions of the goal to avoid. There was no evidence that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted YA perceptions of the goal to provide support ($\beta$ = -.17, $t$ = -1.04, $p$ = .31). Results suggested that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, positively predicted YA perceptions of their own and their partner's goal to influence ($\beta$ = .48, $t$ = 2.33, $p$ = .03). For each one-unit increase in YA perceptions of use of stigma communication during conversations about mental health, there was a .48-unit increase in YA perceptions of the goal to influence. YA perceptions of the use of

stigma communication accounted for 12.7% of the variance in YA perceptions of the goal to influence.

To summarize, there was evidence that YA perceptions of their own and their partner's use of stigma communication during parent-YA conversations about mental health negatively predicted total YA perceptions of affirmation of positive face and affirmation of negative face. Findings also suggested that YA perceptions of their own and their partner's use of stigma communication positively predicted YA perceptions of the task goals to avoid and to influence. Together, these findings provide partial support for *H5a$_i$*.

Table 4.28: Results of General Linear Model Multivariate Regression Analyses for H5a$_i$

| YA Total Perceived Goal | YA total perceptions of stigma communication (IV) | | | |
|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | -2.25* | -.33 | [-.63, -.03] | .12 |
| Attention to negative face | -3.82*** | -.35 | [-.53, -.16] | .28 |
| Attention to the relationship | -.63 | -.13 | [-.55, .29] | .01 |
| Avoidance | 5.12*** | .44 | [.27, .61] | .42 |
| Support | -1.04 | -.17 | [-.51, .17] | .03 |
| Influence | 2.33* | .48 | [.06, .89] | .13 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

### *H5a$_{ii}$-H5a$_v$: YA Perceptions of Stigma Communication (IV) and All DVs*

According to the first half of the fifth set of hypotheses, YA perceptions of their own and their partner's use of stigma communication predict their own and their partner's CA, perceptions of relational distancing, conversation satisfaction, clinical help-seeking attitudes, and non-clinical help-seeking attitudes. Specifically, separate hypotheses for each dependent

variable posited that total YA perceptions of stigma communication would positively predict parent and YA CA and relational distancing, and would negatively predict parent and YA conversation satisfaction, clinical help-seeking attitudes, and non-clinical help-seeking attitudes. Results related to total YA perceptions of stigma communication are presented in Tables 4.29 and 4.30.

Results suggested that YA perceptions of the use of stigma communication during parent-YA conversations about mental health did not significantly predict parent CA ($\beta$ = .10, $t$ = .75, $p$ = .46). However, results demonstrated a significant, positive association between YA perceptions of their own and their partner's use of stigma communication during conversations about mental health and YA CA ($\beta$ = .35, $t$ = 2.29, $p$ = .03), such that for each one-unit increase in YA perceptions of the use of stigma communication, there was a .35-unit increase in YA reports of CA. YA perceptions of the use of stigma communication during parent-YA conversations about mental health accounted for 12.5% of the variance in YA CA related to mental health conversations.

Results suggested that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, positively predicted parent perceptions of relational distancing ($\beta$ = .72, $t$ = 2.38, $p$ = .02), such that for each one-unit increase in YA perceptions of the use of stigma communication, there was a .72-unit increase in parent reports of relational distancing. YA perceptions of the use of stigma communication during parent-YA conversations about mental health accounted for 13.3% of the variance in parent perceptions of relational distancing between themselves and the YAs with whom they engaged in the mental health conversation. YA perceptions of the use of stigma communication did not significantly predict YA perceptions of relational distancing ($\beta$ = .27, $t$ = 1.27, $p$ = .21). There was no evidence that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted parent conversation satisfaction ($\beta$ = .05, $t$ = .30, $p$ = .76) or YA conversation satisfaction ($\beta$ = -.30, $t$ = -1.71, $p$ = .10).

YA perceptions of the use of stigma communication did not significantly predict parent clinical help-seeking attitudes ($\beta$ = -.39, $t$ = -1.92, $p$ = .06). Results did, however, demonstrate that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, inversely predicted YA clinical help-seeking attitudes ($\beta$ = -.83, $t$ = -4.56, $p$ < .001). That is, for each one-unit increase in YA perceptions of the use of stigma communication, there was a -.83-unit decrease in how favorable YA clinical help-seeking attitudes were. YA perceptions of the use of stigma communication accounted for 35.9% of the variance in YA reports of clinical help-seeking attitudes. Results also demonstrated that YA perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, inversely predicted parent non-clinical help-seeking attitudes ($\beta$ = -1.15, $t$ = -2.21, $p$ = .03). That is, for each one-unit increase in YA perceptions of the use of stigma communication, there was a -1.15-unit decrease in how favorable parent non-clinical help-seeking attitudes were. YA perceptions of the use of stigma communication during parent-YA conversations about mental health accounted for 11.7% of the variance in parent reports of non-clinical help-seeking attitudes. However, there was no evidence that YA perceptions of the use of stigma communication significantly predicted YA non-clinical help-seeking attitudes ($\beta$ = .27, $t$ = .46, $p$ = .65).

To summarize, there was evidence that YA perceptions of their own and their partner's use of stigma communication during parent-YA conversations about mental health positively predicted YA CA and parent perceptions of relational distancing, providing partial support for $H5a_{ii}$ *and* $H5a_{iii}$, respectively. Additionally, findings provide partial support for $H5av_{(1)}$ and $H5av_{(2)}$, respectively, given evidence that YA perceptions of their own and their partner's use of stigma communication negatively predicted YA clinical help-seeking attitudes and parent non-clinical help-seeking attitudes.

Table 4.29: Results of General Linear Model Multivariate Regression Analyses for Parent-Reported DVs in $H5a_{ii}$-$H5a_{v}$

| Parent-reported dependent variables | YA total perceptions of stigma communication (IV) | | | |
|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ |
| Communication apprehension | .75 | .10 | [-.17, .36] | .02 |
| Relational distancing | 2.38* | .72 | [.11, 1.32] | .13 |
| Conversation satisfaction | .30 | .05 | [-.28, .38] | .00 |
| Clinical help-seeking attitudes | -1.92 | -.39 | [-.80, .02] | .09 |
| Non-clinical help-seeking attitudes | -2.21* | -1.15 | [-2.20, -.10] | .12 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$

Table 4.30: Results of General Linear Model Multivariate Regression Analyses for YA-Reported DVs in $H5a_{ii}$-$H5a_{v}$

| YA-reported dependent variables | YA total perceptions of stigma communication (IV) | | | |
|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ |
| Communication apprehension | 2.29* | .35 | [.04, .66] | .13 |
| Relational distancing | 1.27 | .27 | [-.16, .69] | .04 |
| Conversation satisfaction | -1.71 | -.30 | [-.65, .05] | .07 |
| Clinical help-seeking attitudes | -4.56*** | -.83 | [-1.19, -.46] | .36 |
| Non-clinical help-seeking attitudes | .46 | .27 | [-.91, 1.45] | .01 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

### *H5b$_i$: Parent Perceptions of Stigma Communication (IV) and Goals (DVs)*

According to hypothesis *5b$_i$*, parent perceptions of their own and their partner's use of stigma communication predict parent perceptions of their own and their partner's attention to

interaction goals during conversations about mental health. Specifically, it was posited that total parent perceptions of stigma communication would separately, negatively predict total parent perceptions of the goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support; whereas, total parent perceptions of stigma communication would separately, positively predict the goals of avoiding and influencing. Results related to total parent perceptions of stigma communication are presented in Table 4.31.

There was no evidence that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted parent perceptions of the goal to affirm positive face ($\beta$ = -.15, $t$ = -1.14, $p$ = .26). Similarly, there was no evidence that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted parent perceptions of the goal to affirm negative face ($\beta$ = -.11, $t$ = -.94, $p$ = .36). Following this same pattern, there was no evidence that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted parent perceptions of attention to the relationship ($\beta$ = .03, $t$ = .17, $p$ = .87).

Results suggested that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, positively predicted parent perceptions of their own and their partner's goal to avoid ($\beta$ = .62, $t$ = 11.83, $p$ < .001). That is, for each one-unit increase in parent perceptions of use of stigma communication during conversations about mental health, there was a .62-unit increase in parent perceptions of the goal to avoid. Parent perceptions of the use of stigma communication accounted for 79.1% of the variance in parent perceptions of the goal to avoid. There also was no evidence that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted parent perceptions of the goal to provide support ($\beta$ = -.14, $t$ = -.88, $p$ = .38). There was no evidence that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted parent perceptions of the goal to influence ($\beta$ = .22, $t$ = 1.29, $p$ = .21).

To summarize, there was evidence that parent perceptions of their own and their partner's use of stigma communication during parent-YA conversations about mental health positively predicted parent perceptions of the goal to avoid. This finding provides partial support for *H5b$_i$*; although, the majority of hypothesized claims were not supported.

Table 4.31: Results of General Linear Model Multivariate Regression Analyses for H5b$_i$

| Parent Total Perceived Goal | Parent total perceptions of stigma communication (IV) | | | |
|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | -1.14 | -.15 | [-.42, .12] | .03 |
| Attention to negative face | -.94 | -.11 | [-.35, .13] | .02 |
| Attention to the relationship | .17 | .03 | [-.34, .40] | .00 |
| Avoidance | 11.83*** | .62 | [.52, .73] | .79 |
| Support | -.88 | -.14 | [-.46, .18] | .02 |
| Influence | 1.29 | .22 | [-.13, .57] | .04 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

### *H5b$_{ii}$-H5b$_v$: Parent Perceptions of Stigma Communication (IV) and All DVs*

According to the second half of the fifth set of hypotheses, parent perceptions of their own and their partner's use of stigma communication predict their own and their partner's CA, perceptions of relational distancing, conversation satisfaction, clinical help-seeking attitudes, and non-clinical help-seeking attitudes. Specifically, separate hypotheses for each dependent variable posited that total parent perceptions of stigma communication would positively predict parent and YA CA and relational distancing, and would negatively predict parent and YA conversation satisfaction, clinical help-seeking attitudes, and non-clinical help-seeking attitudes.

Results related to total parent perceptions of stigma communication are presented in Tables 4.32 and 4.33.

Results demonstrated a significant, positive association between parent perceptions of their own and their partner's use of stigma communication during conversations about mental health and parent CA ($\beta$ = .36, $t$ = 3.85, $p$ < .001). That is, for each one-unit increase in parent perceptions of the use of stigma communication, there was a .36-unit increase in parent reports of CA. Parent perceptions of the use of stigma communication accounted for 28.6% of the variance in parent CA related to mental health conversations. Conversely, parent perceptions of the use of stigma communication did not significantly predict YA CA ($\beta$ = .21, $t$ = 1.60, $p$ = .12).

Results suggested that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, positively predicted parent perceptions of relational distancing ($\beta$ = .93, $t$ = 4.11, $p$ < .001), such that for each one-unit increase in parent perceptions of the use of stigma communication, there was a .93-unit increase in parent reports of relational distancing. Parent perceptions of the use of stigma communication during parent-YA conversations about mental health accounted for 31.4% of the variance in parent perceptions of relational distancing between themselves and the YAs with whom they engaged in the mental health conversation. Parent perceptions of the use of stigma communication did not, however, significantly predict YA perceptions of relational distancing ($\beta$ = .32, $t$ = 1.82, $p$ = .08). Results indicated that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, inversely predicted parent perceptions of conversation satisfaction ($\beta$ = -.43, $t$ = -3.68, $p$ = .001). That is, for each one-unit increase in parent perceptions of the use of stigma communication, there was a -.43-unit decrease in parent conversation satisfaction. Parent perceptions of the use of stigma communication during parent-YA conversations about mental health accounted for 26.8% of the variance in parent conversation satisfaction. Parent perceptions of the use of stigma communication did not, however, significantly predict YA conversation satisfaction ($\beta$ = -.29, $t$ = -1.98, $p$ = .06).

Results indicated that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly, inversely predicted parent clinical help-seeking attitudes ($\beta$ = -.43, $t$ = -2.64, $p$ = .01). That is, for each one-unit increase in parent perceptions of the use of stigma communication, there was a -.43-unit decrease in how favorable parent clinical help-seeking attitudes were. Parent perceptions of the use of stigma communication during parent-YA conversations about mental health accounted for 15.9% of the variance in parent reports of clinical help-seeking attitudes. Parent perceptions of the use of stigma communication did not, however, significantly predict YA clinical help-seeking attitudes ($\beta$ = -.27, $t$ = -1.45, $p$ = .16). Additionally, there was no evidence that parent perceptions of their own and their partner's use of stigma communication during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = -.68, $t$ = -1.50, $p$ = .14) or YA non-clinical help-seeking attitudes ($\beta$ = -.06, $t$ = -.13, $p$ = .90).

To summarize, there was evidence that parent perceptions of their own and their partner's use of stigma communication during parent-YA conversations about mental health positively predicted parent CA and parent perceptions of relational distancing, providing partial support for $H5b_{ii}$ *and* $H5b_{iii}$, respectively. Additionally, findings provide partial support for $H5b_{iv}$ and $H5b_{v(1)}$, respectively. That is, results demonstrated evidence that parent perceptions of their own and their partner's use of stigma communication negatively predicted parent conversation satisfaction and parent clinical help-seeking attitudes.

Table 4.32: Results of General Linear Model Multivariate Regression Analyses for Parent-Reported DVs in $H5b_{ii}$-$H5b_{v}$

| Parent-reported dependent variables | Parent total perceptions of stigma communication (IV) | | | |
|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ |
| Communication apprehension | 3.85*** | .36 | [.17, .55] | .29 |
| Relational distancing | 1.82 | .32 | [-.04, .67] | .08 |
| Conversation satisfaction | -3.68** | -.43 | [-.67, -.19] | .27 |
| Clinical help-seeking attitudes | -2.64** | -.43 | [-.77, -.10] | .16 |
| Non-clinical help-seeking attitudes | -1.50 | -.68 | [-1.60, .24] | .06 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

Table 4.33: Results of General Linear Model Multivariate Regression Analyses for YA-Reported DVs in $H5b_{ii}$-$H5b_{v}$

| YA-reported dependent variables | Parent total perceptions of stigma communication (IV) | | | |
|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ |
| Communication apprehension | 1.60 | .21 | [-.06, .48] | .07 |
| Relational distancing | 4.11*** | .93 | [.47, 1.39] | .31 |
| Conversation satisfaction | -1.98 | -.29 | [-.58, .01] | .10 |
| Clinical help-seeking attitudes | -1.45 | -.27 | [-.65, .11] | .05 |
| Non-clinical help-seeking attitudes | -.13 | -.06 | [-1.07, .94] | .00 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$, *** $p < .001$

### *Regression Models for Help-Seeking Attitudes*

#### *H6a$_i$-H6a$_{vi}$: YA Perceptions of Goals (IV) and Help-Seeking Attitudes (DVs)*

According to the first half of the sixth set of hypotheses, YA perceptions of their own and their partner's interaction goals should predict their own and their partner's (1) clinical help-seeking attitudes and (2) non-clinical help-seeking attitudes. Specifically, separate hypotheses for each interaction goal posited that total YA perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would positively predict parent and YA clinical help-seeking attitudes and non-clinical help-seeking attitudes; whereas, the separate goals of avoiding and influencing would negatively predict parent and YA clinical help-seeking attitudes and non-clinical help-seeking attitudes. Results related to total YA perceptions of each individual interaction goal are presented in Tables 4.34 and 4.35.

There was no evidence that YA perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly predicted parent clinical help-seeking attitudes ($\beta$ = -.00, $t$ = -.01, $p$ = .99) or YA clinical help-seeking attitudes ($\beta$ = .38, $t$ = 1.65, $p$ = .11). Additionally, there was no evidence that YA perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = .75, $t$ = 1.33, $p$ = .19) or YA non-clinical help-seeking attitudes ($\beta$ = .09, $t$ = .14, $p$ = .89). Results also demonstrated no evidence that YA perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly predicted parent clinical help-seeking attitudes ($\beta$ = .22, $t$ = .66, $p$ = .51) or YA clinical help-seeking attitudes ($\beta$ = .41, $t$ = 1.18, $p$ = .25). Results suggested no evidence that YA perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = 1.41, $t$ = 1.72, $p$ = .09) or YA non-clinical help-seeking attitudes ($\beta$ = -.82, $t$ = -.92, $p$ = .36).

Additionally, there was no evidence that YA perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly predicted parent clinical help-seeking attitudes ($\beta$ = .04, $t$ = .24, $p$ = .81) or YA clinical help-seeking attitudes ($\beta$ = -.09, $t$ = -.51, $p$ = .61). There was no evidence that YA perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = -.14, $t$ = -.32, $p$ = .75) or YA non-clinical help-seeking attitudes ($\beta$ = -.13, $t$ = -.29, $p$ = .77). Results indicated a significant, negative association between YA perceptions of their own and their partner's goal to avoid during conversations about mental health and parent clinical help-seeking attitudes ($\beta$ = -.63, $t$ = -2.17, $p$ = .04). That is, for each one-unit increase in YA perceptions of avoidance during conversations about mental health, there was a -.63-unit decrease in how favorable parent clinical help-seeking attitudes were. YA perceptions of the goal to avoid accounted for 11.2% of the variance in parent clinical help-seeking attitudes. Following the same pattern, YA perceptions of their own and their partner's goal to avoid significantly, inversely predicted YA perceptions of clinical help-seeking attitudes ($\beta$ = -.88, $t$ = -2.92, $p$ = .006). That is, for each one-unit increase in YA perceptions of avoidance during conversations about mental health, there was a -.88-unit decrease in how favorable YA clinical help-seeking attitudes were. YA perceptions of the goal to avoid accounted for 18.8% of the variance in YA reports of clinical help-seeking attitudes.

Moreover, there was no evidence that YA perceptions of their own and their partner's goal to avoid during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = -.92, $t$ = -1.15, $p$ = .26) or YA non-clinical help-seeking attitudes ($\beta$ = .50, $t$ = .58, $p$ = .56). There was no evidence that YA perceptions of their own and their partner's goal to provide support during conversations about mental health significantly predicted parent clinical help-seeking attitudes ($\beta$ = -.07, $t$ = -.33, $p$ = .74) or YA clinical help-seeking attitudes ($\beta$ = .14, $t$ = .64, $p$ = .53). There was no evidence that YA perceptions of their own and their partner's goal to provide support during conversations about mental health significantly

predicted parent non-clinical help-seeking attitudes ($\beta$ = .05, $t$ = .09, $p$ = .93) or YA non-clinical help-seeking attitudes ($\beta$ = .31, $t$ = .55, $p$ = .59). There was no evidence that YA perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent clinical help-seeking attitudes ($\beta$ = -.10, $t$ = -.61, $p$ = .54) or YA clinical help-seeking attitudes ($\beta$ = -.19, $t$ = -1.13, $p$ = .27). Similarly, there was no evidence that YA perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = -.42, $t$ = -1.03, $p$ = .31) or YA non-clinical help-seeking attitudes ($\beta$ = .32, $t$ = .72, $p$ = .48).

To summarize, there was little evidence that YA perceptions of their own and their parent's attention to interaction goals predicted parent or YA clinical and non-clinical help-seeking attitudes. However, *H6a$_{iv(1)}$* was supported given findings suggesting that YA perceptions of their own and their partner's goal to avoid inversely predicted parent and YA clinical help-seeking attitudes.

Table 4.34: Results of General Linear Model Multivariate Regression Analyses for Parent-Reported Clinical and Non-Clinical Help-Seeking Attitudes in H6a$_i$-H6a$_{vi}$

| YA Total Perceived Goal | Parent-reported clinical help-seeking attitudes | | | | Parent-reported non-clinical help-seeking attitudes | | | |
|---|---|---|---|---|---|---|---|---|
| | $t$ | $\beta$ | 95% CI | $\eta_p^2$ | $t$ | $\beta$ | 95% CI | $\eta_p^2$ |
| Attention to positive face | -.01 | -.00 | [-.45, .45] | .00 | 1.33 | .75 | [-.40, 1.89] | .05 |
| Attention to negative face | .66 | .22 | [-.44, .87] | .01 | 1.72 | 1.41 | [-.25, 3.07] | .07 |
| Attention to relationship | .24 | .04 | [-.30, .38] | .00 | -.32 | -.14 | [-1.02, .74] | .00 |
| Avoidance | -2.17* | -.63 | [-1.23, -.04] | .11 | -1.15 | -.92 | [-2.53, .70] | .04 |
| Support | -.33 | -.07 | [-.48, .35] | .00 | .09 | .05 | [-1.03, 1.13] | .00 |
| Influence | -.61 | -.10 | [-.42, .22] | .01 | -1.03 | -.42 | [-1.25, .41] | .03 |

*Note.* $N$ = 78. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$

Table 4.35: Results of General Linear Model Multivariate Regression Analyses for YA-Reported Clinical and Non-Clinical Help-Seeking Attitudes in $H6a_i$-$H6a_{vi}$

| YA Total Perceived Goal | YA-reported clinical help-seeking attitudes | | | | YA-reported non-clinical help-seeking attitudes | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | 1.65 | .38 | [-.09, .84] | .07 | 1.69 | .09 | [-1.16, 1.33] | .00 |
| Attention to negative face | 1.18 | .41 | [-.29, 1.10] | .04 | -.92 | -.82 | [-2.63, .99] | .02 |
| Attention to relationship | -.51 | -.09 | [-.45, .27] | .01 | -.29 | -.13 | [-1.07, .80] | .00 |
| Avoidance | -2.92** | -.88 | [-1.49, -.27] | .19 | .58 | .50 | [-1.24, 2.23] | .04 |
| Support | .64 | .14 | [-.30, .58] | .01 | .55 | .31 | [-.83, 1.45] | .01 |
| Influence | -1.13 | -.19 | [-.53, .15] | .03 | .72 | .32 | [-.57, 1.20] | .01 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$

### *$H6b_i$-$H6b_{vi}$: Parent Perceptions of Goals (IV) and Help-Seeking Attitudes (DVs)*

According to the second half of the sixth set of hypotheses, parent perceptions of their own and their partner's interaction goals should predict their own and their partner's (1) clinical help-seeking attitudes and (2) non-clinical help-seeking attitudes. Specifically, separate hypotheses for each interaction goal posited that total parent perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would positively predict parent and YA clinical help-seeking attitudes and non-clinical help-seeking attitudes; whereas, the separate goals of avoiding and influencing would negatively predict parent and YA clinical help-seeking attitudes and non-clinical help-seeking attitudes. Results related to total parent perceptions of each individual interaction goal are presented in Tables 4.36 and 4.37.

Results suggested that parent perceptions of their own and their partner's affirmation of positive face during conversations about mental health significantly, positively predicted parent clinical help-seeking attitudes ($\beta = .50$, $t = 2.51$, $p = .02$). That is, for each one-unit increase in

parent perceptions of attention to positive face, there was a .50-unit increase in how favorable parent clinical help-seeking attitudes were. Parent perceptions of affirmation of positive face accounted for 14.5% of the variance in parent reports of clinical help-seeking attitudes. There was no evidence that parent perceptions of their own and their partner's goal to affirm positive face during conversations about mental health significantly predicted YA clinical help-seeking attitudes ($\beta$ = .33, $t$ = 1.46, $p$ = .15). There also was no evidence that parent perceptions of their own and their partner's goal to affirm positive face during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = .54, $t$ = .98, $p$ = .34) or YA non-clinical help-seeking attitudes ($\beta$ = .32, $t$ = .54, $p$ = .59).

Results indicated that parent perceptions of their own and their partner's affirmation of negative face during conversations about mental health significantly, positively predicted parent clinical help-seeking attitudes ($\beta$ = .52, $t$ = 2.24, $p$ = .03). That is, for each one-unit increase in parent perceptions of negative face, there was a .52-unit increase in how favorable parent clinical help-seeking attitudes were. Parent perceptions of affirmation of negative face accounted for 12% of the variance in parent reports of clinical help-seeking attitudes. Following the same pattern, parent perceptions of their own and their partner's affirmation of negative face significantly, positively predicted YA clinical help-seeking attitudes ($\beta$ = .52, $t$ = 2.09, $p$ = .04). That is, for each one-unit increase in parent perceptions of negative face, there was a .52-unit increase in how favorable YA clinical help-seeking attitudes were. Parent perceptions of attention to negative face accounted for 10.5% of the variance in YA clinical help-seeking attitudes. Results indicated that parent perceptions of their own and their partner's goal to affirm negative face during conversations about mental health significantly, positively predicted parent non-clinical help-seeking attitudes ($\beta$ = 1.41, $t$ = 2.34, $p$ = .03), such that for each one-unit increase in parent perceptions of negative face during conversations about mental health, there was a 1.41-unit increase in how favorable parent non-clinical help-seeking attitudes were. Parent perceptions of affirmation of negative face accounted for 12.9% of the variance in parent reports of non-clinical help-seeking attitudes. However, there was no evidence that parent perceptions

of their own and their partner's goal to affirm negative face during conversations about mental health significantly predicted YA non-clinical help-seeking attitudes ($\beta$ = .57, $t$ = .82, $p$ = .42).

There was no evidence that parent perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly predicted parent clinical help-seeking attitudes ($\beta$ = .04, $t$ = .25, $p$ = .80) or YA clinical help-seeking attitudes ($\beta$ = .14, $t$ = .83, $p$ = .41). Additionally, there was no evidence that parent perceptions of their own and their partner's attention to relational maintenance during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = -.15, $t$ = -.35, $p$ = .73) or YA non-clinical help-seeking attitudes ($\beta$ = .40, $t$ = .91, $p$ = .37). Results did, however, suggest that parent perceptions of their own and their partner's goal to avoid during conversations about mental health significantly, inversely predicted parent clinical help-seeking attitudes ($\beta$ = -.73, $t$ = -3.23, $p$ = .003). For each one-unit increase in parent perceptions of the goal to avoid during conversations about mental health, there was a -.73-unit decrease in how favorable parent clinical help-seeking attitudes were. Parent perceptions of the goal to avoid accounted for 22% of the variance in parent clinical help-seeking attitudes. Following the same pattern, parent perceptions of their own and their partner's goal to avoid significantly, inversely predicted YA clinical help-seeking attitudes ($\beta$ = -.52, $t$ = -2.01, $p$ = .05). That is, for each one-unit increase in parent perceptions of avoidance during conversations about mental health, there was a -.52-unit decrease in how favorable YA clinical help-seeking attitudes were. Parent perceptions of the goal to avoid accounted for 9.8% of the variance in YA help-seeking attitudes. Results also suggested that parent perceptions of their own and their partner's goal to avoid during conversations about mental health significantly, inversely predicted parent non-clinical help-seeking attitudes ($\beta$ = -1.28, $t$ = -2.01, $p$ = .05). That is, for each one-unit increase in parent perceptions of the goal to avoid, there was a -1.28-unit decrease in how favorable parent non-clinical help-seeking attitudes were. Parent perceptions of the goal to avoid during parent-YA conversations about mental health accounted for 9.9% of the variance in parent non-clinical help-seeking attitudes. However, there was no evidence that parent perceptions of their own and their

partner's goal to avoid during conversations about mental health significantly predicted YA non-clinical help-seeking attitudes ($\beta$ = -.25, $t$ = -.35, $p$ = .77).

There was no evidence that parent perceptions of their own and their partner's goal to support during conversations about mental health significantly predicted parent clinical help-seeking attitudes ($\beta$ = .34, $t$ = 1.98, $p$ = .06) or YA clinical help-seeking attitudes ($\beta$ = .34, $t$ = 1.81, $p$ = .08). There also was no evidence that parent perceptions of their own and their partner's goal to support during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = .31, $t$ = .64, $p$ = .53) or YA non-clinical help-seeking attitudes ($\beta$ = -.20, $t$ = -.40, $p$ = .69). Results did indicate that parent perceptions of their own and their partner's goal to influence during conversations about mental health significantly, inversely predicted parent clinical help-seeking attitudes ($\beta$ = -.32, $t$ = -2.01, $p$ = .05). That is, for each one-unit increase in parent perceptions of the goal to influence, there was a -.32-unit decrease in how favorable parent clinical help-seeking attitudes were. Parent perceptions of the goal to influence during parent-YA conversations about mental health accounted for 9.9% of the variance in parent clinical help-seeking attitudes. However, there was no evidence that parent perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted YA clinical help-seeking attitudes ($\beta$ = -.20, $t$ = -1.13, $p$ = .27). There was no evidence that parent perceptions of their own and their partner's goal to influence during conversations about mental health significantly predicted parent non-clinical help-seeking attitudes ($\beta$ = -.17, $t$ = -.40, $p$ = .69) or YA non-clinical help-seeking attitudes ($\beta$ = .28, $t$ = .60, $p$ = .55).

To summarize, there was evidence that parent perceptions of their own and their partner's affirmation of positive face positively predicted parent clinical help-seeking attitudes, providing partial support for $H6b_{i}$. There also was evidence that parent perceptions of their own and their partner's affirmation of negative face positively predicted both parent and YA clinical help-seeking attitudes as well as parent non-clinical help-seeking attitudes. This set of findings provides partial support for $H6b_{ii}$. Additionally, there was partial support for $H6b_{iv}$ given

evidence that parent perceptions of their own and their partner's goal to avoid negatively predicted parent and YA clinical help-seeking attitudes along with parent non-clinical help-seeking attitudes. Lastly, *H6b$_{vi}$* also was partially supported by evidence suggesting that parent perceptions of their own and their partner's goal to influence negatively predicted parent clinical help-seeking attitudes.

Table 4.36: Results of General Linear Model Multivariate Regression Analyses for Parent-Reported Clinical and Non-Clinical Help-Seeking Attitudes in H6b$_i$-H6b$_{vi}$

| Parent Total Perceived Goal | Parent-reported clinical help-seeking attitudes | | | | Parent-reported non-clinical help-seeking attitudes | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face | 2.51* | .50 | [.10, .91] | .15 | .98 | .54 | [-.59, 1.67] | .03 |
| Attention to negative face | 2.24* | .52 | [.05, .99] | .12 | 2.34* | 1.41 | [.19, 2.62] | .13 |
| Attention to relationship | .25 | .04 | [-.29, .37] | .00 | -.35 | .40 | [-.10, .71] | .00 |
| Avoidance | -3.23** | -.73 | [-1.19, -.27] | .22 | -2.01* | -1.28 | [-2.56, .01] | .10 |
| Support | 1.98 | .34 | [-.01, .70] | .10 | .64 | .31 | [-.66, 1.27] | .01 |
| Influence | -2.01* | -.32 | [-.64, .00] | .10 | -.40 | -.17 | [-1.05, .71] | .00 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$, ** $p < .01$

Table 4.37: Results of General Linear Model Multivariate Regression Analyses for YA-Reported Clinical and Non-Clinical Help-Seeking Attitudes in $H6b_i$-$H6b_{vi}$

| Parent Total Perceived Goal | YA-reported clinical help-seeking attitudes | | | | YA-reported non-clinical help-seeking attitudes | | | |
|---|---|---|---|---|---|---|---|---|
| | *t* | *β* | 95% CI | $\eta_p^2$ | *t* | *β* | 95% CI | $\eta_p^2$ |
| Attention to positive face2 | 1.46 | .33 | [-.13, .79] | .05 | .54 | .32 | [-.89, 1.53] | .01 |
| Attention to negative face | 2.09* | .52 | [.02, 1.03] | .11 | .82 | .56 | [-.81, 1.93] | .02 |
| Attention to relationship | .83 | .14 | [-.21, .49] | .02 | .91 | .40 | [-.49, 1.30] | .02 |
| Avoidance | -2.01* | -.52 | [-1.05, .00] | .10 | -.35 | -.25 | [-1.68, 1.18] | .00 |
| Support | 1.81 | .34 | [-.04, .72] | .08 | -.40 | -.20 | [-1.23, .82] | .00 |
| Influence | -1.13 | -.20 | [-.57, .16] | .03 | .60 | .28 | [-.66, 1.21] | .01 |

*Note.* $N = 78$. CI = confidence interval. $\eta_p^2$ = variance accounted for.
* $p \leq .05$

**Multilevel models**

Given the correlational evidence suggesting nonindependence for YA and parent perceptions of the goal to avoid and reports of clinical help-seeking attitudes, REML was used to test hypotheses related to these dependent variables ($H5a_{i(4)}$ and $H5b_{i(4)}$ and $H6a_{i\text{-}vi(1)}$, $H6b_{i\text{-}vi(1)}$, $H5a_{v(1)}$, and $H5b_{v(1)}$, respectively), while accounting for the nested nature of the data (Hox, 2010; Kenny et al., 2006; Snijders & Bosker, 1999). Because preliminary analyses also demonstrated weak correlations between total parent and total YA perceptions of corresponding interaction goals and stigma communication, it was appropriate for MLM models to simultaneously include parent and YA predictors with the combined dependent variable (e.g., parent-reported clinical help-seeking attitudes and YA-reported clinical help-seeking attitudes). For both sets of hypotheses tested, an initial step was to examine the unconditional models in which dependent variables, specified at Level 1, were modeled without any predictors. To the extent that results of the unconditional models suggested significant between-dyad variance in the dependent variables, full models, which included predictors, were tested. In calculating full models,

independent variables were specified at Level 2, and fixed effects were examined to obtain information about the direction and impact of the predictor variable on the dependent variable.

Results related to each dependent variable are displayed in separate tables (see Tables 4.38 and 4.39). Across both tables, the first row conveys results of the unconditional model, demonstrating whether or not follow-up models with predictors should be pursued. The baseline model also provides a fixed effect estimate that denotes the grand mean of the dependent variable across all dyads. In the separate tables, each row following the baseline row represents separate analyses in which one predictor variable was included at Level 2. The results of interest to this study include the fixed effects coefficient estimate (*b*), which indicates the direction of the association and the unit change in the dependent variable with every unit change in the independent variable in the model, as well as the *t* statistic, which provides information about the significance of the fixed effect. If the *t* statistic value is significant, this suggests that the independent variable specified at Level 2 is statistically significantly related to the dependent variable at Level 1. Lastly, the proportion of variance in the dependent variable that was accounted for by the independent variable in the model is also presented in each table. The proportion of variance value is obtained by calculating the decrease in variance component values between the unconditional model and the conditional model.

The first set of hypotheses ($H5a_{i(4)}$ and $H5b_{i(4)}$) tested using HLM 7 software posited that parent and YA perceptions of the use of stigma communication during conversations about mental health would positively predict parent and YA perceptions of the goal to avoid during parent-YA mental health conversations. Results are displayed in Table 4.38. Findings from the unconditional model suggested evidence of a significant amount of variance in perceptions of the goal to avoid $\chi^2 = 96.09$, df = 38, $p < .001$). When the full model was tested, there was evidence that parent and YA perceptions of the use of stigma communication significantly, positively predicted parent and YA perceptions of their own and their partner's goal to avoid, $t(37) = 6.68$, $p < .001$, such that as perceptions of the use of stigma communication increased by one unit, perceptions of the goal to avoid increased by .44 units. The proportion of variance in the goal to

avoid that was accounted for by perceptions of stigma communication was 9%. These results provide support for $H5a_{i(4)}$ and $H5b_{i(4)}$.

Table 4.38: Results of MLM Analysis for Stigma Communication Predicting Avoidance

| Model | Perceptions of the goal to avoid (DV) | | | |
|---|---|---|---|---|
| | *b* | *SE* | *t* | Variance accounted for |
| Unconditional | 1.33 | .06 | 21.95*** | |
| Perceptions of stigma communication | .44 | .07 | 6.68*** | .09 |

* $p < .05$, ** $p < .01$, *** $p < .001$

The next set of hypotheses ($H6a_{i\text{-}vi(1)}$, $H6b_{i\text{-}vi(1)}$, $H5a_{v(1)}$, and $H5b_{v(1)}$) tested indicated that parent and YA perceptions of their own and their partner's interaction goals and use of stigma communication would separately predict parent and YA clinical help-seeking attitudes. Specifically, separate hypotheses for each interaction goal posited that total parent and YA perceptions of the separate goals of affirming positive face, affirming negative face, maintaining the relationship, and providing support would positively predict parent and YA clinical help-seeking attitudes; whereas, the goal of avoiding, the goal of influencing, and the use of stigma communication would negatively predict parent and YA clinical help-seeking attitudes. Results of the MLM analyses are displayed in Table 4.39.

Findings from the unconditional model suggested a significant amount of variance in perceptions of clinical help-seeking attitudes ($\chi^2 = 79.90$, df = 38, $p < .001$). When separate full models were tested, there was evidence that parent and YA perceptions of affirming positive face, $t(37) = 2.43$, $p = .02$, affirming negative face, $t(37) = 2.71$, $p = .01$, and the goal to support, $t(37) = 2.35$, $p = .02$, significantly, positively predicted parent and YA clinical help-seeking attitudes. That is, as perceptions of affirmation of positive face increased by one unit, there was a .42-unit increase in how favorable clinical help-seeking attitudes were; as perceptions of

affirmation of negative face increased by one unit, there was a .52-unit increase in how favorable clinical help-seeking attitudes were; and as perceptions of the goal to support increased by one unit, there was a .34-unit increase in how favorable clinical help-seeking attitudes were.

Additionally, results from tests of separate full models indicated that parent and YA perceptions of the goal to avoid, $t(37) = -3.26$, $p = .002$, and the use of stigma communication, $t(37) = -2.49$, $p = .02$, significantly, inversely predicted parent and YA clinical help-seeking attitudes. That is, for each one-unit increase in perceptions of the goal to avoid, there was a -.63-unit decrease in how favorable parent and YA clinical help-seeking attitudes were, and as perceptions of the use of stigma communication increased by one unit, there was a -.35-unit decrease in how favorable parent and YA clinical help-seeking attitudes were. There was, however, no evidence that parent and YA perceptions of attention to the relationship, $t(37) = .67$, $p = .51$, or the goal to influence, $t(37) = -1.91$, $p = .06$, predicted parent and YA clinical help-seeking attitudes. The proportion of variance in clinical help-seeking attitudes that was accounted for by perceived interaction goals or stigma communication ranged from 0% to 9%. These results provide support for $H6a_{i(1)}$, $H6b_{i(1)}$, $H6a_{ii(1)}$, $H6b_{ii(1)}$, $H6a_{v(1)}$, $H6b_{v(1)}$, $H6a_{iv(1)}$, $H6b_{iv(1)}$, $H5a_{v(1)}$, and $H5b_{v(1)}$. Results of MLM analyses aligned with results from GLM analyses in significance and direction of the outcomes. However, results from MLM analyses suggested that when parent and YA perceptions of the goal to support were included as one independent variable in the model with parent and YA clinical help-seeking attitudes as the dependent variable, the goal to support was found to significantly positively predict parent and YA clinical help-seeking attitudes. Conversely, results of GLM multivariate analyses indicated no significant relationship between parent and YA perceptions of the goal to support and parent and YA clinical help-seeking attitudes.

Table 4.39: Results of MLM Analysis for Perceptions of Own and Partner's Interaction Goals and Use of Stigma Communication Predicting Parent and YA Clinical Help-Seeking Attitudes

| Model | Clinical help-seeking attitudes (DV) | | | |
|---|---|---|---|---|
| | *b* | *SE* | *t* | Variance accounted for |
| Unconditional | 5.43 | .11 | 51.90*** | |
| Attention to positive face | .42 | .17 | 2.43* | .05 |
| Attention to negative face | .52 | .19 | 2.71* | .06 |
| Attention to the relationship | .09 | .14 | .67 | .00 |
| Goal to avoid | -.63 | .19 | -.33** | .09 |
| Goal to support | .34 | .15 | 2.35* | .05 |
| Goal to influence | -.26 | .14 | -1.91 | .03 |
| Use of stigma communication | -.35 | .14 | -2.49* | .05 |

* $p < .05$, ** $p < .01$, *** $p < .001$

# Chapter 5: Discussion and Conclusion

This study was intended to help extend current understanding of and literature related to parent and YA communication about stigmatized health topics, specifically mental health. Previous research had suggested that mental health and mental illness, while important, remain some of the most stigmatized health topics in the United States (Phelan et al., 2000; WHO, 2017). This stigma associated with mental health and mental illness is just one reason that engaging in conversations about this topic can be difficult, particularly for parents and YAs (Arnett, 1998, 2001, 2004; Donovan, 2015; Flood-Grady & Koening Kellas, 2018). Research has demonstrated that family communication shapes health-related attitudes, beliefs, and behaviors and often perpetuates mental health and mental illness stigma, which impedes use of mental healthcare services (Corrigan, 2004; Dennis & Chung-Lee, 2006; Eisenberg et al., 2009; Flood-Grady & Koenig Kellas, 2018; Ormondroyd et al., 2008). Pursuing interaction goals that uphold relevant identities, attend to the relationship, and accomplish instrumental goals can also contribute to the potential complexity of parent-YA communication about mental health. As such, this investigation was designed to explore how interaction goals were related to outcomes of parent-YA communication about mental health.

A large body of research has suggested that when communicators attend to relevant interaction goals, their communication is considered higher in quality—that is, more competent, effective, persuasive, appropriate, supportive, sensitive, successful, helpful, and positive—than communication that does not attend to normatively relevant interaction goals (Burleson & Samter, 1985; Caughlin, 2010; Caughlin, et al., 2008; Goldsmith, 1992, 2004; Goldsmith et al., 2006; Lambert & Gillespie, 1994; O'Keefe & McCornack, 1987; O'Keefe & Shepherd, 1987). Therefore, using a multiple goals theoretical approach, this study sought to explain how parent and YA perceptions of their own and their conversation partner's attention to relevant interaction goals during conversations about mental health were associated with more or less favorable individual (e.g., clinical help-seeking attitudes) and relational (e.g., relational distancing) outcomes. The model of stigma communication also was used to guide hypotheses related to

parent and YA perceptions of the use of stigma communication during mental health conversations (Smith, 2007, 2011). In this chapter, results are summarized and discussed, theoretical and practical implications are considered, and limitations and directions for future research are presented.

## DISCUSSION OF RESULTS

### Own & Partner Perceptions of Interaction Goals & Stigma Communication

The first set of hypotheses ($H1a_{i\text{-}vi}$ and $H1b_{i\text{-}vi}$) proposed that participant perceptions of their partner's goal attention would be positively associated with the partner's perceptions of their own goal attention. There was no association between YA perceptions of parent attention to interaction goals and parent perceptions of their own attention to interaction goals ($H1a_{i}$–$H1a_{iv}$). There also was no association between YA perceptions of parent stigma communication and parent perceptions of their own stigma communication ($H1a_{vi}$). However, there was a positive association between parent perceptions of YAs' goal to avoid and YA perceptions of their own goal to avoid ($H1b_{iv}$). Additionally, there was a positive relationship between parent perceptions of YA stigma communication and YA perceptions of their own stigma communication ($H1b_{vi}$). Overall, these findings suggest that although parents and YAs were asked to reflect on a conversation in which they had engaged together, parent and YA perceptions of each other's attention to interaction goals and use of stigma communication largely did not relate to their perceptions of their own attention to the same goals and use of stigma during conversations about mental health. That is, there was no concordance between what parents thought their own goals for the conversation were and what YAs thought parent goals were for the same conversation. Similarly, with the exceptions of the goal to avoid and use of stigma communication, there was no agreement between what YAs perceived to be their own goals for the conversation and what parents perceived to be YA goals for the conversation. Despite the apparent lack of concordance between YAs' and parents' own reports, there were consistent correlations between YA perceptions of their own goal attention and their perceptions

of their parents' goal attention. The same was true for correlations between parents' reports of their own goal attention and reports of their YA children's goal attention.

Although extant research has demonstrated that it is possible for communicators to accurately evaluate and report on their own and their partner's goals for a given interaction, there is also scholarship suggesting that perceptions of goals may be shaped by dynamics and bias beyond the interaction of interest (Bem, 1972; Caughlin, 2010; Wilson, 2007). Communicators can also have biased perceptions of their own behaviors within conversations, which can be exacerbated by social desirability or health contexts (e.g., Beck et al., 1979; Canary, 2003). The weak or non-existent relationships between participant perceptions of their partner's goals and the partner's perceptions of their own goals for their conversation about mental health could be influenced by such factors. Additionally, some interaction goals may have been apparent to the communicator, but may not have been expressed in such a way that their conversation partner could have readily evaluated (Tracy & Eisenberg, 1990).

However, with regard to the demonstrated relationship between parent and YA reports of YA's goal to avoid and parent and YA reports of YA's use of stigma communication during parent-YA conversations about mental health, it is possible that YAs were more obvious or direct about their goal to either avoid or engage in the conversation as well as about their use of stigma communication (Tracy & Eisenberg, 1990). Therefore, alignment in parent and YA perceptions of these YA goals may have been facilitated. That said, separate accounts of parent and YA *perceptions* of—rather than actual—attention to goals and the use of stigma communication were the focus of this study. Some previous research has indicated that parents and their children may have different perceptions of the communication patterns in which they engage together. Specifically, such discrepancies in parent and child perceptions have been found in relation to communication patterns associated with potentially difficult topics such as conflict and sexuality (Caughlin & Malis, 2004; Kirkman et al., 2005). Findings from the current study offered insight into the possible perceptual differences between parents and YAs in interpreting goal attention as well as possible bias and idiosyncrasies that may have contributed

to limited associations between parent and YA perceptions of the goals they thought they were enacting during the mental health conversation and the goals their conversation partner thought they were pursuing (e.g., Noller & Feeney, 2004).

**Influence of Perceived Stigma Communication on Perceived Interaction Goals**

The next set of hypotheses (*H5a*$_i$-*H5b*$_i$) proposed that total perceptions of own and partner use of stigma communication would predict total perceptions of own and partner attention to interaction goals. Findings suggested that total YA perceptions of their own and their partner's use of stigma communication during parent-YA conversations about mental health negatively predicted total YA perceptions of affirmation of positive face and, separately, YA perceptions of affirmation of negative face. Also, total YA perceptions of their own and their partner's use of stigma communication positively predicted total YA perceptions of the task goal to avoid and, separately, the task goal to influence (*H5a*$_i$). Additionally, findings indicated that total parent perceptions of their own and their partner's use of stigma communication positively predicted total parent perceptions of the goal to avoid (*H5b*$_i$).

The more that YAs perceived that they and their parents used stigma communication during conversations about mental health, the less YAs perceived that they and their parents were affirming positive face and negative face. Using stigmatizing language, dismissing mental health issues, and minimizing mental health-related topics as part of a conversation about mental health resulted in YAs perceiving less attention to the face wants of being valued and accepted (i.e., positive face) as well as of being autonomous and independent (i.e., negative face). Perceived attention to positive and negative face provides ways to capture whether or not competing or conflicting interaction goals are being pursued (Brown & Levinson, 1987; Goldsmith, 2004; Scott, 2010). These findings suggested that stigma communication may impede communicators' ability to effectively attend to competing goals during parent-YA conversations about mental health. That is, perhaps communication that stigmatizes mental health and related topics constrains communicator's attention to other interaction goals or limits

communicator's abilities to recognize that identity goals are being pursued. It also is possible that stigma communication as perceived by YAs is interpreted as face threatening by YAs. Although it is unclear how stigma communication was used or toward what it was directed, previous research has indicated that stigma is damaging to those who are stigmatized and potentially to those who hear stigmatizing messages (Flood-Grady & Koening Kellas, 2018; Goffman, 1963; Smith, 2007). Findings from the present study suggested that YA perceptions of stigma communication may also be damaging to YAs' perceptions of being accepted and having their autonomy respected. Given that this was only the case for YAs, perhaps there are generational differences in what is perceived as stigmatizing talk or in expectations surrounding facework during parent-YA conversations. That is, perhaps parent perceptions of affirming positive face and negative face are not as impacted by the use of stigma communication as are YA perceptions of attention to positive and negative face.

Additionally, when YAs perceived the use of stigma communication during mental health conversations with their parents, they perceived greater attention to the goal to influence. It may be that when YAs perceived the use of stigma communication, YAs also sensed that persuasion was occurring. Perhaps when stigmatization was present, YAs perceived that they and their parents were focused on convincing each other to consider mental-health-related topics differently, which can also be face threatening (O'Keefe, 1988; Wilson et al., 1998). Therefore, findings from this study again suggested that YA perceptions of the use of stigma communication itself may be face threatening for YAs, but not for parents. This may especially be the case given that perceptions of stigma communication were not associated with the goal to support, which previous research has suggested can be another interpretation of the goal to influence, particularly in health contexts (Goldsmith et al., 2006).

Both parent and YA perceptions of stigma communication predicted perceptions of the goal to avoid for both parents and YAs. When parents and YAs perceived that stigmatizing language was being used during conversations about mental health, perhaps they also felt that they or their conversation partner were attempting to avoid a topic of relevance to the mental

health conversation. Perceiving that stigma was present may have hindered the ability of parents and YAs to fully elaborate on the topic of mental health in the ways they would have liked to. That is, perceptions of stigma communication may have constrained communicators' desire or ability to be forthcoming in these conversations, instead prompting topic avoidance. This may especially be the case if one or both family members has an undisclosed mental health concern or history of mental illness or treatment for psychological distress. In such circumstances, if stigma is perceived, then fully engaging in a conversation about mental health may put communicators at risk for negative evaluations (Greene, 2015; Link & Phelan, 2001, 2006; Pahwa et al., 2017). Previous research on family communication about mental health has posited that topic avoidance also may perpetuate stigmatization of mental health and related topics by signifying that it is taboo or forbidden (Afifi & Guerrero, 2000; Greenwell, 2018; Ormondroyd et al., 2008). Thus, there may be a cycle at play in the context of mental health communication within families: stigma about mental health is perceived, the stigmatized topic is avoided, stigmatization of that topic is perpetuated, and so forth. Taken together, findings related to associations between perceptions of stigma communication and perceptions of attention to interaction goals indicated that stigma may complicate parent-YA conversations about mental health by constraining communicators' abilities to preserve face and fully engage with mental health-related topics.

**Influence of Perceived Interaction Goals & Stigma Communication on Reported Outcomes**

Finally, the largest set of hypotheses (*H2a*$_i$-*H4b*$_{vi}$, *H5a*$_{ii}$-*H5a*$_v$, *H5b*$_{ii}$-*H5b*$_v$, and *H6a*$_i$-*H6b*$_{vi}$) proposed that parent and YA perceptions of interaction goals and use of stigma communication would predict parent and YA communication apprehension, relational distancing, conversation satisfaction, and clinical and non-clinical help-seeking attitudes. Testing these hypotheses illuminated that, in some instances, parent and YA perceptions of interaction goals and the use of stigma communication during conversations about mental health did predict parent and YA individual and relational outcomes. Although not all hypotheses received full or partial support, findings did suggest some emergent patterns (see Table 5.1).

Table 5.1: Statistically Significant Associations between Total Perceived Interaction Goals and Reported Outcomes

| Total perceived interaction goal | | Communication apprehension | | Relational distancing | | Conversation satisfaction | | Clinical help-seeking attitudes | | Non-clinical help-seeking attitudes | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Parent report | YA report | Parent report | YA report | Parent report | YA report | Parent report | YA report | Parent report | YA report |
| Attention to positive face | Parent | - | | - | | + | | + | | | |
| | YA | | | | | | + | | | | |
| Attention to negative face | Parent | | | - | | | | + | + | + | |
| | YA | | | | | | | | | | |
| Attention to relational maintenance | Parent | | | | - | | | | | | |
| | YA | | | | | | | | | | |
| Goal to avoid | Parent | + | + | + | | - | - | - | - | - | |
| | YA | + | + | + | + | | - | - | - | | |
| Goal to support | Parent | | | - | | | | | | | |
| | YA | | - | | - | | + | | | | |
| Goal to influence | Parent | + | | | | | | - | | | |
| | YA | | + | | | | | | | | |
| Use of stigma communication | Parent | + | | + | | - | | - | | | |
| | YA | | + | + | | | | | - | - | |

*Note.* "+" denotes a significant positive association, "-" denotes a significant negative association.

Most notably, parent and YA perceptions of the goal to avoid consistently impacted individual and relational outcomes for both parents and YAs. That is, total parent perceptions and total YA perceptions of the goal to avoid both separately predicted greater communication apprehension (CA) and, separately, less positive clinical help-seeking attitudes for parents and YAs. Furthermore, total parent perceptions of the goal to avoid during conversations about mental health predicted less satisfaction with the conversation for both parents and YAs. Total YA perceptions of the goal to avoid predicted greater relational distancing for both parents and YAs. For both parents and YAs, outcomes predicted by parent and/or YA perceptions of greater attention to the goal to avoid were unfavorable—greater CA, less positive clinical help-seeking attitudes, less conversation satisfaction, and greater relational distancing.

Given that the predominant implied task goal for parents and YAs was to engage in a conversation about mental health, the goal to avoid directly contradicts the main interaction goal associated with the purpose of this communicative event (Dillard et al., 1989). In general, previous research has indicated that communication failing to attend to the conventionally relevant goals of a given interaction is viewed as less appropriate and less effective (e.g., Goldsmith, 2004; O'Keefe & Shepherd, 1987). Additionally, perceived avoidance may be interpreted as inconsiderate, rude, or hurtful, which could help explain the relationship between perceptions of the goal to avoid and parent and YA reports of relational distancing (Brown & Levinson, 1987; Goffman, 1967; Vangelisti & Young, 2000). However, it is important to consider the circumstances behind the goal to avoid during conversations about mental health. While findings from the present study cannot shed light on such motivations, some research has suggested that the relational impact of enacted topic avoidance can be mitigated by the reasons for avoidance (e.g., Caughlin & Afifi, 2004; Donovan-Kicken & Caughlin, 2010). Within parent-child communication, conflict and protection of self or relationship have been identified as reasons for topic avoidance (Golish & Caughlin, 2002).

In addition to findings related to perceptions of the goal to avoid, YAs' own perceptions of greater attention to the goal to support predicted less YA CA related to parent-YA

conversations about mental health. Parent perceptions of greater attention to positive face predicted less parent CA related to parent-YA conversations about mental health. When parents perceived that communicators attended to positive face wants of acceptance and likeability, and when YAs perceived that communicators were reassuring them and demonstrating that they would be there for each other, they had less anxiety about talking to their family member about mental health. Reassuring and supportive communication have been found to be more effective at comforting, which is likely to influence the extent to which an individual feels nervous or fearful (Burleson et al., 2009). For parents and YAs, their own perceptions of attention to the goal to influence and attention to stigma communication were associated with greater CA. Research has suggested that when YAs experience CA about communicating with their parents, the quality of their communication can be negatively affected (Daly, McCroskey, Ayers, Hopf, & Ayers, 1997). Findings from this study suggested that this relationship may also function in the other direction. That is, that lower quality communication (i.e., those associated with perceptions of the goal to influence and use of stigma communication) about mental health may negatively affect YA and parent CA.

As for relational distancing, YA perceptions of greater attention to the goal to support and, separately, parent perceptions of greater attention to maintaining the relationship were associated with less relational distancing for YAs. For parents, their own perceptions of greater attention to the goals to support, to affirm positive face, and to affirm negative face separately predicted less relational distancing; whereas, parent and YA perceptions of more stigma communication predicted greater relational distancing. Perceiving that a communication partner has the goal to maintain the relationship may imply caring for and valuing the relationship, so it would follow that both parents and YAs report feeling less distant in that relationship. Existing evidence also has suggested that support can be perceived as an effective relational maintenance strategy (e.g., Haas, 2002). Although perceptions of stigma communication only influenced parent perceptions of relational distancing, extant research has found that messages that minimize mental health are related to greater relational distancing for YAs, and that overall,

dismissive messages, such as messages that incorporate stigma communication, are associated with feelings of decreased closeness between communicators (Greenwell, 2018; Vangelisti & Young, 2000).

As for conversation satisfaction, YA perceptions of greater attention to the goal to support and, separately, YA perceptions of the goal to affirm positive face predicted greater satisfaction with the mental health conversation. Parent conversation satisfaction was predicted by parent perceptions of greater attention to positive face and, separately, by parent perceptions of less use of stigma communication. Research has indicated that the extent to which communicators experience satisfaction with a conversation is considered a response to the accomplishment of interaction goals (Hecht, 1978). As such, research has demonstrated that people tend to be more satisfied with conversations when their positive social identities are reinforced (e.g., Martin et al., 2004). Additionally, perceptions of less use of stigma communication may have resulted in fewer opportunities for interactants, namely parents, to feel shame, judgment, or conflict related to the mental health topics posed by the conversation task or their YA conversation partners, leading to greater satisfaction with the conversation (Goffman, 1963, 1967; Goldsmith, 2004).

More positive clinical help-seeking attitudes for YAs were predicted by parent perceptions of greater affirmation of negative face and, separately, by YA perceptions of less stigma communication. For parents, more positive clinical help-seeking attitudes were separately predicted by parent perceptions of greater affirmation of positive, parent perceptions of greater affirmation of negative face, parent perceptions of less attention to the goal to influence, and parent perceptions of less use of stigma communication. These findings related to perceptions of stigma communication were unsurprising in that stigma is a primary barrier to clinical help-seeking for mental health concerns, particularly for YAs (Eisenberg et al., 2009). Additionally, for YAs and parents, perceptions of respect for autonomy, and for parents, perceptions of less persuasion may promote the idea that seeking professional help for psychological distress is acceptable. Wilson and colleagues (2015) found that dilemmas often

accompany family communication about seeking professional help for mental health concerns. Results of the current study align with findings and recommendations from Wilson et al.'s (2015) research, which has suggested that minimizing face threats can help communicators navigate the challenges of talking about mental health topics, including clinical help seeking, in ways that are associated with desirable help-seeking outcomes.

Finally, YA non-clinical help-seeking attitudes were not predicted by parent or YA perceptions of attention to any interaction goal or use of stigma communication. However, more positive parent non-clinical help-seeking attitudes were predicted by parent perceptions of greater attention to negative face and, separately by parent perceptions of less use of stigma communication. For parents, these findings reflected a pattern similar to parent outcomes for clinical help-seeking attitudes. Once again, perceiving that their autonomy was respected and that mental health topics were not stigmatized during parent-YA conversations about mental health may help parents feel freer to hold positive attitudes and make independent decisions about non-clinical help seeking for psychological distress.

Taken together, these findings demonstrated that in the context of parent-YA conversations about mental health, perceptions of attention to different interaction goals have different implications for parents and YAs. For example, YA perceptions of the goal to support were more influential for YA outcomes than were perceptions of the goal to support for parent outcomes, just as parent perceptions of affirmation of positive face were more impactful on parent outcomes than were perceptions of affirmation of positive face for YA outcomes. However, despite these differences, separate perceptions of greater attention to the goals of affirming positive face, affirming negative face, and supporting, along with separate perceptions of less attention to the goal to avoid, the goal to influence, and the use of stigma communication were associated with more favorable outcomes for both parents and YAs. It is important to remember, however, that interaction effects among perceptions of interaction goals and stigma communication were not assessed as part of the current study. As such, although the combinations of perceptions of attention to these goals may vary with respect to how they

influence individual and relational outcomes, the direction of the associations are consistent across parents and YAs. That is, in general, perceptions of greater attention to the goals of affirming positive and negative face, of supporting, and perceptions of less attention to the goals to avoid and influence and less use of stigma communication constitute high quality parent-YA conversations about mental health. Perceptions of attention to the goal of maintaining the relationship were only associated with one desirable outcome (i.e., less relational distancing) for YAs, so this goal may be less relevant to context of parent-YA mental health communication, and thus, may be less necessary for high-quality parent-YA conversations about mental health than are the other goals outlined above.

It is interesting to note that, for the most part, parents' individual and relational outcomes seemed to be influenced by their own perceptions of attention to interaction goals and the use of stigma communication, with the exceptions of YA perceptions of the goal to avoid and YA perceptions of stigma communication. Similarly, YA outcomes seemed to be primarily influenced by their own perceptions of goal attention and use of stigma communication. However, when parent perceptions of goals and stigma were related to YA outcomes, there was more variety in the goals and the outcomes that were affected. For example, parent perceptions of maintaining the relationship, affirming negative face, and avoiding were separately associated with YA communication apprehension, relational distancing, and clinical help-seeking attitudes in different ways. This suggests that parent perceptions of mental health conversations influenced YA individual and relational outcomes more than YA perceptions influenced parent outcomes. Although there has been some evidence indicating that children influence their parents' health behaviors, it has been well-established that parents shape their children's health beliefs and behaviors (Aday & Eichhorn, 1972; Dailey et al., 2014; Koenig Kellas, 2010).

### THEORETICAL IMPLICATIONS

Findings from this study demonstrated that communicator perceptions of the extent to which interaction goals are attended to yield better or worse individual and relational outcomes.

This supports previous theorizing that a multiple goals perspective is not only useful as a theory of message production but also can be utilized to assess how people interpret or perceive communication (e.g., Donovan-Kicken & Caughlin, 2010; Caughlin, 2010; Scott, 2010). That is, although this study did not assess the actual enactment of goal attention, results indicated that communicators' perceptions of their own and their partner's attention to relevant goals influence their own and their partner's individual and relational outcomes. Such findings support evidence that communication can influence relevant outcomes through perceptual processes (e.g., Caughlin & Golish, 2002; Scott, 2010). Caughlin and Golish (2002), for instance, have found stronger evidence that perceptions of topic avoidance in both YA romantic relationships and parent-YA relationships are associated with relational dissatisfaction than is actual enactment of topic avoidance. Findings from the current investigation support that perceptions of own and partner's avoidance meaningfully impact own and partner's outcomes as do other relevant interaction goals, which suggests that further examining the effects of perceptions of attention to other relevant interaction goals may be warranted in other contexts.

Talking about mental health is necessary and important, particularly in the context of parent-YA relationships since mental illness often occurs during young adulthood and stigma toward mental health and mental illness may be perpetuated through family communication (Flood-Grady & Koening Kellas, 2018; SAMHSA, 2015). Additionally, parent-YA relationships are often in a state of change or renegotiation (e.g., YAs moving away from their parents, from traditional parent-child to peer-like dynamic; Arnett, 1998, 2001, 2004; Dubas & Petersen, 1996). Although this relational and health context are not completely distinct from others in which a multiple goals theoretical perspective has been applied (e.g., Caughlin et al., 2008, 2009; Caughlin & Scott, 2010; Imai & Dailey, 2016; Scott & Caughlin, 2014; Scott et al., 2013), mental health encompasses a unique set of attributes that distinguishes it from other stigmatized health topics previously examined using this framework. For example, mental illness can be chronic or acute, caused by a combination of biological and environmental factors, and treatment or management of mental health concerns is often associated with additional stigma (Corrigan,

2004; Eisenberg et al., 2009; Mayo Clinic, 2015). As such, this study offers an investigation of perceptions of attention to interaction goals in a distinct and socially-relevant context.

Similarly, findings from this study provided evidence of goals that are salient to parent-YA conversations about mental health, as well as some insight into interaction goals that may not be as relevant to this context. Affirmation of positive face, affirmation of negative face, the goal to support, the goal to influence, and particularly, the goal to avoid, separately appeared to be germane to this communicative context. Building from this base, future research can begin to explore simultaneous attention to these (and other) relevant interaction goals. These goals also provide a starting point for testing interactions between and among goals relevant to parent-YA communication about mental health and for investigating how communicators prioritize attention to multiple interaction goals in ways that may facilitate or inhibit favorable outcomes. Also, such findings point to the heuristic value of examining simultaneous attention to multiple goals in combination with stigma communication, which also appears to be germane to this communicative context.

In addition to empirically identifying goals that are salient to parent-YA communication about mental health, this study provided some insight into the normative relevance of the goal to maintain the parent-YA relationship. That is, perceptions of this relational goal did not emerge as particularly salient to the parent-YA context of this study. Future research should consider other relational goals (e.g., improving the relationship, negotiating a more peer-like relationship) that may be pertinent to parent-YA mental health communication. Perhaps by further considering the unique nature of parent-YA relationships, including shifts from a traditional parent-child dynamic to a relationship of equals, adjustments in geographic distance, and differentiation from parents, scholars can identify relational goals that more directly relate to this specific relationship type within the mental health context.

The current study also adds to literature extending Goldsmith's (2001, 2004) work on the dilemmas of attending to interaction goals to the possible dilemmas of managing interaction goals when stigma is particularly salient, such as during communication about mental health

(e.g., Wilson et al., 2015). Specifically, drawing upon Goffman's (1963) seminal work on stigma and the model of stigma communication (MSC; Smith, 2007, 2011) in conjunction with a multiple goals perspective enabled examination of the ways perceptions of stigma communication were associated with perceptions of goal attention. Findings from this study demonstrated that perceptions of the use of stigma may further complicate already challenging communicative circumstances by constraining attention to other relevant interaction goals, consistently resulting in unfavorable outcomes. Extant research has suggested that stigma interferes with individuals' help seeking for psychological distress and that stigma associated with mental health and mental illness may complicate attempts to persuade or give advice related to mental-health help seeking (Corrigan, 2004; Eisenberg et al., 2009; Wilson et al., 2015). Current findings not only offered support for these claims, but they also provided evidence that perceptions of stigma communication may in fact hinder attention to other relevant interaction goals, including affirmation of negative face, affirmation of positive face, and engaging with the topic of interest. As such, future research should investigate the potential that perceptions of or enacted stigma communication during conversations about stigmatized health topics may result in more challenging and less effective persuasion and advice-giving attempts. This present study suggests that the combination of theoretical frameworks related to a multiple goals perspective and stigma may be useful for further exploring the role of stigma in the dilemmas of discussing health belief or behavior changes during communication about stigmatized health topics.

In addition to demonstrating the utility of uniting the multiple goals theoretical perspective with MSC, the present study is one of the first to apply MSC to a parent-YA context. Few studies have used MSC in interpersonal contexts (cf. Smith, 2014), but existing literature points to the perpetuation of stigma through family communication about mental illness (e.g., Flood-Grady & Koenig Kellas, 2018). As such, parent-child or parent-YA contexts are ripe for examining the ways in which stigma is communicated between these family members and the resulting effects of communicated stigma on individual and relational outcomes. Although the current study did not explore actual use of the message choices—marking, labeling,

responsibility, and peril—outlined by MSC, findings demonstrated the relevance of stigma communication in parent-YA communication about mental health. This study also extended the ideas of MSC to assessment of perceptions of stigma communication, and findings related to perceptions of own and partner's use of stigma communication not only predicted attention to relevant interaction goals, but also consistently resulted in undesirable outcomes for YAs and particularly parents. These findings suggested that perceptual processes may be pertinent to interpretations of stigma communication and the subsequent desirability of outcomes. Although the actual use of stigma communication was not assessed as part of this investigation, exploring potential variance in the impact of enacted and perceived stigma communication could be a valuable application of MSC, particularly given how deeply-rooted stigmatizing language (e.g., metaphors, hyperbole) can be in the ways that people communicate about stigmatized topics (Scheff, 1971).

### PRACTICAL IMPLICATIONS

By studying parent-YA communication about mental health through perceptions of attention to interaction goals during a mental health conversation, first steps have been taken to better understand what constitutes higher and lower quality conversations about mental health and which goals influence relevant individual and relational goals for parents and YAs. With this deeper understanding, evidence-based recommendations can be made for parents and YAs who would like to talk about mental health but are unsure of how to do so in ways that will benefit themselves, their family member, and their relationship. Overall, findings from the present study provide some suggestions for how interactants can engage in a conversation about mental health—a potentially challenging or taboo topic—and achieve favorable outcomes. In fact, findings from this study support the idea that parent-YA conversations about mental health are complex communicative situations in which multiple interaction goals are relevant, often competing, and perhaps difficult to manage. Therefore, it may first be helpful to verify for parents and YAs that conversations about mental health may be challenging but are manageable.

Such validation could be particularly reassuring to family members experiencing uncertainty or apprehension prior to or during this type of difficult conversation. Communication that affirms others' thoughts, feelings, and emotions (i.e., validation) has been associated with perceptions of effective support and comforting (Burleson et al., 2009; Burleson & Goldsmith, 1998).

Another practical recommendation that may benefit parents and YAs is to encourage both interactants to engage in, rather than avoid, the topic at hand during mental health conversations. Overall, parent and/or YA perceptions of the goal to avoid during these parent-YA conversations resulted in undesirable outcomes, including more relational distancing and communication apprehension and less positive clinical help-seeking attitudes. It also may be helpful for interactants to explain why they avoid certain topics or to ask one another about motivations for the perceived avoidance given that extant research has indicated that some justifications for topic avoidance can mitigate unfavorable outcomes (e.g., Donovan-Kicken & Caughlin, 2010; Donovan-Kicken, McGlynn, & Damron, 2012). Although the present study did not evaluate how parents and YAs enacted the goal to avoid, future research should assess whether some ways of engaging in topic avoidance during conversations about mental health (e.g., indirect, subtle, or benevolent avoidance) are associated with more or less favorable outcomes for communicators (e.g., Donovan-Kicken et al., 2012). Beyond simply not evading the mental health topic, previous research has also suggested that more fully elaborating on the reasons for beliefs, attitudes, and decisions that may be addressed during health conversations also can contribute to favorable outcomes for communicators in complex interactions (e.g., Scott, 2010; Scott & Caughlin, 2014). The present study did not assess perceptions of the goal to elaborate; however, exploration of this goal and reasons for avoidance in mental health conversations may be fruitful avenues for future research.

Although this study found that various interaction goals are relevant to parent-YA conversations about mental health, the relational goal of maintaining the relationship did not appear to be as germane or influential as were identity and task goals for YA, and especially parent, outcomes. Given this finding and the complex nature of talking about mental health, it

may be advantageous to recommend that parents and YAs prioritize attention to identity goals (i.e., affirmation of positive and negative face) and task goals (e.g., engaging in the conversation) as they communicate about mental health with one another. Perceptions of these goal categories consistently affected perceptions of relational distancing along with other individual outcomes more so than perceptions of the goal to maintain the relationship. So, even if parents and YAs are concerned with protecting the closeness of their relationships during mental health conversations, attending to these other interaction goals may serve that function better than attending to that goal of maintaining the relationship. While there may be other relational goals salient to parent-YA communication about mental health, offering communicators a prioritization of goals to consider managing may reduce the complexity of the situation and help them navigate the conversation in more successful ways.

A final recommendation arising from this study's findings is to avoid using stigma communication or stigmatizing language as part of parent-YA conversations about mental health. Not only do perceptions of stigma communication appear to further complicate attention to other relevant goals for both parents and YAs, but perceptions of the use of stigma communication also relate to more communication apprehension, more relational distancing, less conversation satisfaction, less positive clinical help-seeking attitudes, and less positive non-clinical help-seeking attitudes for parents and/or YAs. Furthermore, it could be beneficial to help parents and YAs identify what constitutes stigma communication by offering examples of and alternatives to stigmatizing messages. Findings from the present study do not provide such exemplars; however, detailed tips for the types of language to avoid as well as other ways of speaking about mental health that would not likely lead to perceptions of the use of stigma communication can be drawn from extant literature such as Smith's (2007, 2011) model of stigma communication and Greenwell's (2018) work on normalizing and strategizing messages about mental health.

Additionally, the elicited talk method used in the current study may be valuable for helping to guide or prompt parent-YA conversations about mental health. After completing the study, several participants indicated to the researcher that the conversation was a positive

experience for them. For example, parents and YAs alike shared comments such as, "Can we sign up to do this every week?", "That was such an interesting conversation," "That was such a bonding moment for us," and "It will make it easier for us to talk about this again." Such unsolicited comments along with a better understanding of the types of mental health interactions that lead to more or less favorable outcomes suggest that prompting a semi-structured conversation about mental health may be helpful for parents and YAs as they initiate and engage in talk about this complex and challenging topic.

Specifically, prompting a conversation that begins with a warm-up activity (i.e., planning a vacation together) and includes subsequent topic-relevant questions that gradually increase in intensity may be particularly useful. Beginning with a warm-up activity before moving on to the more complex health-related portion of conversation may help put parents and YAs at ease, making them less defensive or better able to communicate in open, flexible, effective ways (e.g., Donovan et al., 2019; Rossing & Hoffmann-Longtin, 2016). A conversation guide may serve as a low-stakes way to initiate a difficult conversation about a taboo topic or one surrounded by uncertainty and stigma (e.g., Van Scoy, Reading, Scott, Green, & Levi, 2016; Van Scoy et al., 2017a, 2017b). Of course, as findings from the current study suggested, the *quality* of these conversations, or the ways in which parents and YAs actually speak about mental health topics, have implications for YA and parent individual and relational outcomes. Therefore, a conversation guide such as this should incorporate evidence-based communication recommendations like those outlined above in order to help ensure high quality communication between parents and YAs as they communicate about mental health. This type of self-guided, communication-focused intervention could have implications for educators, health-care providers, and mental health professionals who may be in positions to suggest a conversation guide to parents or YAs who want to or need to talk to their family member about mental health or mental illness.

## LIMITATIONS AND OPPORTUNITIES FOR FUTURE RESEARCH

As with all research, this study has its limitations. As such, results should be interpreted in light of them. Limitations related to study design, sampling, and measurement are presented below. Along with these, directions for future research are proposed.

### Methodological Considerations

This study was designed to account for and reflect the geographic distance experienced by many parent-YA dyads by allowing for both face-to-face and remote conversations and questionnaire completion (Arnett, 2004; Dubas & Petersen, 1996). Although this flexibility provided a way for co-located and dispersed dyads to participate, it also limited the level of control present during data collection. That is, some participating dyads completed the conversation and questionnaire with both members meeting face-to-face with the researcher, while other dyads participated with one member calling in by speaker phone or video conference and the other member meeting in-person with the researcher. Providing various communication channels through which to participate likely influenced, at a minimum, social cues and nonverbal communication variables, which may have impacted participant conversations and survey responses (e.g., Rains, Brunner, Akers, Pavlich, & Tsetsi, 2016; Walther & Parks, 2002).

In addition to the option of virtual or in-person participation, given the potentially sensitive nature of the topic of conversation as well as the desire to promote realistic conversations between dyad members, the study was designed so that participating dyads could select the location in which at least one dyad member would meet with the researcher face-to-face (e.g., Sillars, 1991; Caughlin & Vangelisti, 1999). As such, dyads engaged in study tasks in numerous locations, including an on-campus lab, a student union, coffee shops, and participant homes. Again, building this flexibility into the design constrained the level of control present in carrying out the study by allowing for variance in potentially influential variables such as perceived privacy, confidentiality, comfort, and naturalness of the conversation (Zietlow & Sillars, 1988). For example, participants who met the researcher in a coffee shop may have felt

that their conversation could be heard by others; whereas, those who completed participation in their homes may have experienced greater comfort and perceived privacy as they engaged in the conversation and completed the questionnaire. Although a majority of dyads comprised one remote participant and one participant meeting with the researcher in the on-campus lab, the lack of a consistent data collection site and the option to participate in-person or via remote connection may have influenced dyad interactions in potentially meaningful ways (e.g., Gardner, 1997). Similarly, both virtual and face-to-face interactions in the laboratory or in more familiar data collection settings likely added elements related to mediated communication (e.g., varying social cues) or environment (e.g., noise levels) that may have influenced participants, their conversations, and their survey responses in ways that were not accounted for in this study.

Selection bias, which can affect the validity and generalizability of study results, is another limitation of the present study, primarily as an artifact of the recruitment efforts employed (Berk, 1983). That is, recruitment materials included information advertising the study as exploring parent and YA conversations about mental health. Given the highly stigmatized nature of mental health and related topics, incorporating this specific information in recruitment materials may have deterred interested individuals from reaching out about participating in the study. Moreover, including details about the mental health emphasis of this study may have prompted participation by individuals who are more comfortable discussing difficult topics or those who do not find mental health a taboo topic within their families. Snowball sampling, which relies on initial recruits to select with whom in their social networks to share information about the study, was also used to recruit. This sampling technique often produces a nonrandom sample and may have resulted in more homogenous dyads agreeing to participate (i.e., those comfortable with the topic of mental health; Berk, 1983; Van Meter, 1990). Although it is unknown from these data, the homogeneity of participating dyads also could have resulted in participants of a similar socioeconomic status, which may influence the extent to which people perceive clinical mental-health help seeking as a viable or accessible option. In addition to possibly affecting reports related to help-seeking, this sampling technique

may have produced a sample of volunteer participants who do not need as much explicit relational maintenance during conversations as might other types of parent-YA dyads.

Altogether, bias in the selection process may have influenced this study by reducing representation and limiting variations in interactions, both contributing a more homogenous dataset and decreased generalizability (e.g., Valdez & Kaplan, 1998; Van Meter, 1990). For future studies exploring communication related to stigmatized or taboo topics, providing a more general description of the focus of the study (e.g., conversations about health) in recruitment materials may help reduce selection bias, and thus possibly generate greater variance in conversation content, dyad comfort with the topic, and individual survey responses. However, a recruitment approach that conceals the specific purpose of the study, may increase participant drop-out rates. Additionally, Institutional Review Board requirements may be more rigid with the inclusion of recruitment materials with a less specific or obscured description of the study. For example, participant signatures may be required on consent forms, which would complicate a study designed to facilitate remote participation. The researcher may also be required to debrief participants following their participation, which could add time to an already lengthy participation session.

**Sampling Considerations**

The small sample size is also a limitation of the present study. Initially, this study worked under the assumption that parent and YA data would be dependent, requiring an analytic technique, such as MLM, that accounted for nonindependent nested data. This assumption about the data and anticipated analysis plan guided the decision to obtain data from 39 dyads (i.e., 78 individuals). However, when statistically testing the dependent-data assumption, results revealed that parent and YA data were primarily independent and should therefore be analyzed using a statistical procedure that is appropriate for independent data. For correlation analyses, a minimum sample size of 100 is generally recommended; however, adequate power (i.e., between .80 and .90) can be obtained with an *N* of 78 (Warner, 2013). Sample size recommendations for

regression analyses with one predictor variable suggest that a sample of 52 is adequate but that a sample of 105 is more appropriate for detecting small effect sizes (Green, 1991; Harris, 2013). A small sample size along with an apparent selection bias also contributed to a relatively homogenous sample. The majority of participants were female (75.64%) and white (46.75%). Therefore, although this study aimed to explore parent-YA conversations about mental health, the results of the study may be more narrowly applicable to the context of mother-daughter relationships. The relative racial and ethnic homogeneity of the sample also could have impacted the variance of mental-health help-seeking attitudes reported by participants in this study (e.g., Masuda et al., 2009).

**Measurement Considerations**

In addition to methodological and sampling concerns, there are a number of measurement-related limitations that should be taken into account. First, although this study relied on MSC to amplify the multiple goals approach, the four components of stigma communication—marking, labeling, blaming, and danger—were not specifically measured as part of the study (Smith, 2007, 2011). Rather, MSC was loosely used as a guide for conceptualizing stigma and assessing perceptions of the use of stigma communication with three overarching stigma communication items. Future investigations of communicated stigma in parent-YA conversations about mental health should explicitly assess the four message choices outlined by MSC.

Next, some items included in the two measures assessing perceptions of own and partner attention to interaction goals and stigma communication appeared to be poorly worded. These items were: (1) “I didn’t want to put pressure on my parent/child,” and “My parent/child didn’t want to put pressure on me,” which were intended to assess respondent perceptions of affirmation of negative face, and (2) “I wanted my relationship with my parent/child to get stronger by talking about these issues,” and “My parent/child wanted their relationship with me to get stronger by talking about these issues,” which were meant to measure respondent

perceptions of attention to relational maintenance. Reliability analyses as well as participant inquiries during questionnaire completion revealed these items to be problematic.

For the first set of items described above, negative wording (e.g., "didn't want to…") appeared to contribute to participant confusion in understanding and responding to the items, so much so that results of reliability analyses recommended the items be dropped from the instruments altogether in order to improve reliability. Additionally, previous research has demonstrated that evaluating attention to negative face via self- and other-report can be challenging and often results in low alpha reliabilities (e.g., $\alpha = .67$, $\alpha = .60$; see Guntzviller & MacGeorge, 2013; Scott, 2010). This pattern of difficulty in reliably capturing data related to negative face may suggest that additional research should be done to refine instruments and items used to assess this construct from self- and other-report perspectives.

Reliability results and questions from participants, particularly from YAs, also prompted the researcher to more closely examine the second set of items related to assessing the relational maintenance goal as described above. After inspection, it became apparent that these items, emphasizing the desire for the parent-YA relationship "to get stronger," more closely aligned with the relational goal of improving, building, or strengthening the relationship rather than the relational goal of maintaining the relationship (Canary & Dainton, 2003; Caughlin, 2010). Although it is not impossible that some parents and YAs might seek to improve their relationships by engaging in communication about sensitive or taboo topics, this study did not set out to evaluate this relational goal, nor was the goal of strengthening the parent-YA relationship identified as germane to the context of mental health conversations. Therefore, rather than asking participants to respond to items corresponding to one, coherent relational goal, it is possible that, especially for YA respondents, this set of items introduced another, distinct relational goal that was not salient to the current study.

Partially stemming from these issues with problematic items, another concern related to the instruments assessing perceptions of own and partner interaction goals and stigma communication deals with scale reliabilities and CFA results. Although the perceptions of own

and partner interaction goals and stigma communication measures were primarily compiled using items and subscales from existing, theoretically-grounded measures, these measures and items had not been previously well-established. Additionally, each subscale included only three items, which can result in low reliability coefficients (Tavakol & Dennick, 2011). As such, it was a challenge to obtain high reliability coefficients for subscales included in these measures. Some reliabilities were within the range of acceptability, but few were considered excellent. Because scale reliability is necessary for questionnaire data to be considered valid, it is important to interpret the results of this study with this limitation in mind.

Moreover, CFA results were not as straightforward as anticipated. While it was suspected that some similarity among constructs measured by these instruments may be present, initial CFA results did not indisputably support the proposed factor structure. Follow-up CFAs were conducted after adjusting for the following: (1) stigma communication as a separate latent variable from attention to interaction goals, (2) similarity between the positive face and support constructs as well as between the negative face and influence constructs, and (3) just-identified models for the goal to maintain the relationship and use of stigma communication (See Chapter Four for additional details; Kenny & Milan, 2011). For both instruments, these adjustments resulted in three- and two-factor models specifying task and identity goals, respectively. Although not expected or ideal, these factor-structures demonstrated adequate fit to the data. Taken together, these measurement issues indicate a need to continue exploring valid ways of assessing perceptions of own and partner goal attention and use of stigma communication via self- and other-report questionnaires. Further identifying and testing the conceptual distinctions between similar constructs could be helpful for refining and crafting questionnaire items that more clearly distinguish between, for example, the goal of supporting and the goal of attending to positive face.

Finally, there are limitations associated with the way in which own and partner perceptions of goals and stigma communication were treated in analyses overall. Specifically, each participants' perceptions of their own and their partner's interaction goals and stigma

communication were mathematically combined and averaged to obtain seven total scores for each participant (i.e., one for stigma communication and one for each individual goal assessed). Although this procedure was parsimonious, it relied on combining participant perceptions of their own goals with participant perceptions of their partner's goals, introducing a unit of analysis—participant perceptions of specific goal attention for the entire conversation—that disregarded whose goal attention (or stigma communication) was most impactful. Obtaining mean scores of participant perceptions also may have negated meaningful variance between, for example, parent perceptions of their own attention to negative face and parent perceptions of their partner's attention to negative face. Thus, the variance in data was potentially reduced and the nuance of subsequent results was likely constrained by this treatment of perceptual data. An alternative way to handle these data would have been to treat each account of participant perceptions of own and partner goals and stigma communication as separate variables, which would likely provide additional specificity and distinction to findings overall.

## CONCLUSION

Although some communication scholars (e.g., Arroyo & Segrin, 2013; Bauer, 2011; Flood-Grady & Koenig Kellas, 2018; Greenwell, 2018; Imai & Dailey, 2016; Scott et al., 2013; Segrin, 2001, 2013) have investigated stigma and communication related to mental health and mental illness, these have remained underexplored contexts in the field of interpersonal communication. The quality of parent-YA communication about mental health also has been largely omitted from investigation. The current study sought to fill these gaps in the literature by assessing the quality of parent-YA conversations about mental health through parent and YA perceptions of attention to relevant interaction goals and the use of stigma communication. Previous research situated in a variety of contexts, including those related to stigmatized health topics, has suggested that the extent to which relevant goals are pursued during interactions is associated with higher and lower quality communication and more and less favorable outcomes.

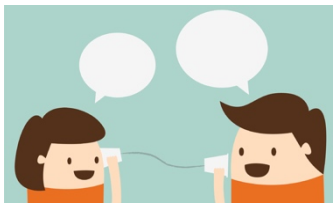
Findings from the present study, which relied on a multiple goals theoretical perspective and the model of stigma communication, indicated that parent and YA perceptions of their own and their partner's attention to relevant interaction goals and use of stigma communication yield more and less favorable outcomes for both parents and YAs. Most notably, parent and YA perceptions of greater attention to the goal to avoid consistently influenced parent and YA outcomes in undesirable ways, such as resulting in greater communication apprehension and less positive clinical help-seeking attitudes for both communicators. Moreover, findings suggested that overall perceptions of the use of stigma communication may constrain affirmation of positive face, affirmation of negative face, and the goal to engage with mental health topics. Although this investigation represents a first step in better understanding parent-YA communication about mental health, these findings provide insight into the interaction goals that are salient to parent-YA conversations about mental health and the extent to which perceptions of attention to these goals influence relevant parent and YA outcomes. This study also demonstrates the heuristic value of exploring the role of stigma in complicating pursuit of interaction goals during conversations about stigmatized health topics.

# Appendices

## APPENDIX A

Participant Recruitment Materials

*Recruitment flyer*



**Seeking young adults and one of their parents**
**for a study about mental health**

Communication Studies researchers at the University of Texas at Austin are conducting a study about how young adults and their parents talk about mental health. Participation involves having a face-to-face or technologically-mediated conversation with your parent and completing an online questionnaire. The estimated time commitment for this study ranges from about 15 to 75 minutes. To participate, young adults must be between the ages of 18 and 24 years old and able to have a conversation with a parent.

**Participating pairs will receive $20 ($l0/person).**

If you are interested in participating or would like to learn more, please contact:
**Mackenzie Greenwell**
**mackenzie.greenwell@utexas.edu**

*Online recruitment text*

Seeking young adults (ages 18 to 24) and one of their parents for a study about mental health.

Communication Studies researchers at the University of Texas at Austin are conducting a study about how young adults and their parents talk about mental health. Participation involves having a face-to-face or technologically-mediated conversation with your parent and completing an online questionnaire. The estimated time commitment for this study is ranges from about 15 to 75 minutes.

To participate, young adults must be between the ages of 18 and 24 years old and able to have a face-to-face or technologically-mediated conversation with a parent. Participating pairs will receive $20 ($10 per individual). If you are interested in participating or would like to learn more, please contact Mackenzie Greenwell at mackenzie.greenwell@utexas.edu.

## APPENDIX B

Consent Form

**Consent for Participation in Research**

**Introduction:** The purpose of this form is to provide you with information that may affect your decision to participate in this research study. Your participation is completely voluntary and you may stop at any point in the study without penalty. If you do choose to halt your participation, you may decline to answer any question, and you have the right to withdraw from participation at any time. Withdrawal will not affect your relationship with The University of Texas in anyway. If you do not want to participate either simply stop participating at any point. You may contact the researcher at any time in the event that any unanticipated questions or concerns arise. Read the information below and please consider any additional information you would like to obtain before deciding whether or not to take part in this research study. If you decide to be involved in this study, this form will be used to record your consent.

**Conducted by:** Mackenzie Greenwell, Ph.D. student
The University of Texas at Austin, Department of Communication Studies
mackenzie.greenwell@utexas.edu

**Supervised by:** Dr. Erin Donovan, Associate Professor

**The purpose of this study:** to explore conversations between parents and their young adult children about mental health. You are free to contact the investigator using the information above. You are eligible to complete this study if you are between the ages of 18 and 24 years old and are able to have a face-to-face or technologically-mediated conversation with one of your parents.

**If you agree to participate:**
You will be asked to engage in a face-to-face or technologically-mediated conversation about mental health with one of your parents and to complete an online questionnaire. On average conversation should take approximately 20 minutes. The online questionnaire should take approximately 15 minutes.

Each pair will be offered $20 ($10 per person) for completing the study.

**Risks and benefits of being in the study:**
This study may involve risks that are currently unforeseeable. If you wish to discuss the information above or any other risks you may experience, you may email the investigator listed above. If you do participate and experience unexpected distress, you are encouraged to call the following phone number or visit the following website where you can find local counseling and support services (1-800-273-TALK; http://www.mentalhealthamerica.net/finding-therapy).

Researchers who have conducted similar studies have reported that people often find it interesting or helpful to have an opportunity to talk about health-related topics with a family member. Your participation also helps researchers better understand how families talk about mental health, which could lead to recommendations to other people about what might be helpful when having such discussions. You can also obtain a summary of the results of this study by contacting the primary investigator after August 2019.

**Confidentiality and privacy protections:**
Information that you share during this study will be kept confidential. The questions you answer with your parent/child will be private, which means the researcher will not be present during the discussion. Your discussion is also meant to be confidential, and the researchers ask that you do not share anything said during the study with others unless you have permission from your parent/child to do so. The researchers will do everything to protect your confidentiality, but cannot guarantee that your parent/child will not share what you have said with others. When your audio-recorded conversation is transcribed, all identifying information will be left out and pseudonyms will be used in place of names so that you are not identifiable in the transcript. A digital copy of the audio recording will be kept indefinitely on a password-protected computer, so it is very unlikely that anyone besides the researchers will hear it. If it becomes necessary for the Institutional Review Board to review the study records, information that can be linked to you will be protected to the extent permitted by law. Your research records will not be released without your consent unless required by law or a court order.

The data collected from this study will be presented to other researchers and written up for publication, but no information that could identify you will be included in any reports about the study.

**Participation or withdrawal**
Your participation in this study is completely voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time. Withdrawal will not affect your relationship with The University of Texas in anyway. If you do not want to participate either simply stop participating or let the researcher know.

**Contacts**
If you have any questions about the study please email Mackenzie Greenwell at mackenzie.greenwell@utexas.edu.

**Questions about your rights as a research participant**
If you have questions about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the Institutional Review Board by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu.

**Participation**

You have been informed about this study's purpose, procedures, possible benefits and risks, and you are encouraged to print a copy of this form for your records. You have been informed that you can ask any questions at any time. You voluntarily agree to participate in this study. By proceeding on to the conversation portion of the study, you are consenting to participate. You are not waiving any of your legal rights.

Thank you!

## APPENDIX C

Conversational Task

*Instructions: We'd like to ask you to have a discussion with one another about a few different topics, most of which are health-related. To make sure your conversation is audio recorded, please make sure you press the "record" button before you begin talking. Even though your conversation is being audio recorded, everything you say will be kept confidential.*

*The goal of this study is to learn more about how parents and their young adult children talk about a variety of topics, including mental health and mental illness. There is no right or wrong way to have this conversation. We are simply interested in what goes on during these kinds of discussions, so please talk as you would if this discussion topic came up naturally during a regular conversation. Try to be as honest as possible. For example, feel free to ask each other questions, clarify, interrupt, take turns, etc.*

*To help you begin this conversation, we have prepared six cards containing questions related to different topics. Please have one person read the first card out loud and then talk about the topic for as long as you want. There is no time limit. When you have nothing more to say about the first topic, please read the second card out loud and talk about the second topic for as long as you want. Continue reading the cards out loud until all six discussion topics have been covered. Again, the goal of this part of the study is to help you have a natural discussion, so please feel free to revisit a previous topic even if you have moved onto a different card.*

Card 1:
As a warm-up activity, we'd like to have you begin by imagining that you have the opportunity to go on a trip together. Together, we would like you to plan that trip. Consider where you would like to go. Where will you stay? How will you prepare for the trip? What will you do when you are on your trip (for example, activities, relax, etc.)?

Card 2:
Now that you're warmed up, we'd like you to move on to discussing the topic cards related to mental health. These are the parts of your conversation you'll be asked to reflect on once you're finished with your conversation. So, after you're done with this conversation and have moved on to the next part of the study, you'll be asked to think about the mental health parts your discussion, rather than on the warm-up activity you just completed.

For the first part of your discussion related to mental health, we're curious about how people define mental health and mental illness. What are your thoughts? How do these health topics relate to physical health? How do each of you take care of your own health?

Card 3:
Do either of you know someone who has experienced mental health issues (for example, anxiety, depression, addiction, eating disorders, stress, etc.)? What was this person's experience like for them? What was it like for you or what were your impressions of this person's experience?

Include any information that seems relevant, such as the type of mental health problem, what they did to manage it (for example, telling loved ones, going to the doctor, taking prescribed medication, doing nothing, exercising, etc.), how it influenced their life, etc. You may feel free to include yourselves in this response if applicable.

Card 4:
There are many causes of mental health concerns and mental illness. What are your thoughts and beliefs about the possible factors contributing to mental illness?

Card 5:
People deal with their mental health concerns in many ways. For example, people can take medication, go to therapy, receive in-patient or outpatient care, join a support group, confide in a loved one, or avoid the health concern altogether. If either of you were to experience a short-term or long-term mental health concern, what types of care do you think you would seek out? What types of care would you avoid? Why? What does each of you see as the advantages and disadvantages of receiving care for mental health concerns in these ways? Are there any circumstances that would change whether or not you would want a particular kind of help for a mental health concern?

Card 6:
What else would you like to talk with one another about before ending the conversation?

*After you have completed your conversation, you may stop the audio recorder by pressing the "stop" button. Next, let the researcher know that your conversation is over, so each of you can separately complete a survey for the final part of the study. Thank you!*

## APPENDIX D

Measures

**Conversation Satisfaction Measure (Hecht, 1978)**

*Instructions: Now we'd like you to think about the health-related parts of the conversation you just had. Please keep these parts of your conversation in mind as you respond to the following statements. We'd like to ask you about your general thoughts on the conversation you just had. Please tell us how much you agree or disagree with these statements about your discussion.*

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

1. I was dissatisfied with the conversation. (R)
2. I'm glad we had this conversation.
3. Nothing was accomplished by having this conversation. (R)
4. I was pleased with the conversation.
5. I wish we had not had this conversation. (R)
6. Having this conversation was productive.
7. I was satisfied with the conversation.

Scoring

(R) indicates items that will be reverse coded. After appropriate items are reverse coded, the mean score will be calculated. Higher scores will indicate higher levels of conversational satisfaction.

**Conversational Realism (Scott, 2010)**
*Instructions: Still keeping in mind the health-related parts of your conversation, we'd like to know how realistic you think the conversation you had with your parent/child was. Please tell us how natural you think the conversation was by selecting the number that best reflects your thoughts*.

Strongly Disagree 1 2 3 4 5 6 7 Strongly Agree

1. This conversation was realistic.
2. I could easily imagine having a conversation like this one on our own.
3. This discussion was not natural. (R)
4. This conversation was typical of how we would talk about mental health apart from this research study.
5. My parent/child and I talked naturally in this conversation.

Scoring
(R) indicates items that will be reverse coded. After appropriate item(s) are reverse coded, the mean score will be calculated. Higher scores will indicate more realistic conversations.

**Perceptions of Partner Interaction Goals & Stigma Communication**

*Instructions: Whenever people have a conversation, they are not just talking—they are also trying to do things, like informing, persuading, or sharing feelings. Below we ask you about some things people might try to do in the type of conversation you just had. Please select the appropriate number to let us know how much you agree with the following statements about what you think your parent/child was trying to do in the conversation. Once again, when responding to these statements, please think about the health-related portions of your conversation.*

Strongly Disagree 1 2 3 4 5 Strongly Agree

Affirming the positive face of the other

1. My parent/child was trying to let me know that he/she appreciates me.
2. My parent/child was trying to let me know that he/she values me.
3. My parent/child wanted me to know that he/she accepts me.

Affirming the negative face of the other

4. My parent/child didn't want to put pressure on me.
5. My parent/child wanted to respect my choices.
6. My parent/child wanted to respect my beliefs and attitudes.

Maintaining the relationship

7. My parent/child wanted to protect our relationship.
8. My parent/child didn't want to damage our relationship.
9. My parent/child wanted our relationship to get stronger by talking about these issues.

Avoidance

10. My parent/child wanted to avoid talking about mental health and related topics.
11. My parent/child wanted to change the subject away from the topic of mental health and related matters.
12. My parent/child wanted to say very little about mental health and related topics.

Support

13. My parent/child was trying to reassure me.
14. My parent/child was trying to let me know that he/she supports me.
15. My parent/child was trying to show that they are there for me.

Influence

16. My parent/child wanted to influence me.
17. My parent/child wanted to change my mind.
18. My parent/child was trying to persuade me.

Stigma

19. My parent/child was minimizing mental health or related topics.
20. My parent/child was dismissive of mental health or related topics.

21. My parent/child was stigmatizing mental health or related topics.

Scoring
See scoring instructions below.

**Perceptions of Own Interaction Goals & Stigma Communication**

*Instructions: Now we'd like to know what **you** think about **your** goals in the conversation you just had. Please select a number to let us know how much you agree with the following statements about what **you** were trying to do in the conversation. As you consider the statements below, please focus on the health-related portions of your conversation.*

Strongly Disagree 1 2 3 4 5 Strongly Agree

Affirming the positive face of the other

1. I was trying to let my parent/child know that I appreciate him/her.
2. I was trying to let my parent/child know that I value him/her.
3. I wanted to let my parent/child know that I accept him/her.

Affirming the negative face of the other

4. I didn't want to put pressure on my parent/child.
5. I wanted to respect my parent's/child's choices.
6. I wanted to respect my parent's/child's beliefs and attitudes.

Maintaining the relationship

7. I wanted to protect my relationship with my parent/child.
8. I didn't want to damage my relationship with my parent/child.
9. I wanted my relationship with my parent/child to get stronger by talking about these issues.

Avoidance

10. I wanted to avoid talking about mental health and related topics.
11. I wanted to change the subject away from the topic of mental health and related matters.
12. I wanted to say very little about mental health and related topics.

Support

13. I was trying to reassure my parent/child.
14. I was trying to let my parent/child know that I support him/her.
15. I was trying to show my parent/child that I am there for him/her.

Influence

16. I wanted to influence my parent/child.
17. I wanted to change my parent's/child's mind.
18. I was trying to persuade my parent/child.

Stigma

19. I was minimizing mental health or related topics.
20. I was dismissive of mental health or related topics.
21. I was stigmatizing mental health or related topics.

Scoring

The mean score for each individual perceived goal type and stigma communication will be calculated. These separate scores will then be combined with their corresponding or matching separate scores from Perceptions of Partner Interaction Goals & Stigma Communication measure, resulting in seven total scores for each dyad member—one score corresponding with each individual goal (i.e., affirming positive face, affirming negative face, maintaining the relationship, avoidance, support, influence) and stigma communication that are assessed in both measures. Higher scores will indicate greater attention to the given interaction goal and greater use of stigma communication during the parent-YA conversation about mental health.

**Clinical Help-Seeking Attitudes (Mackenzie et al., 2004)**
*Instructions: Still thinking about the mental health-related parts of your conversation, please think about the ways in which this conversation has influenced your attitudes toward mental health, then respond to the statements below. There are no right or wrong answers here.*

Strongly disagree 1 2 3 4 5 6 7 Strongly Agree

Psychological Openness:

1. Mental health concerns, like many things, tend to work out by themselves. (R)
2. There are certain issues, which should not be discussed outside of one's immediate family. (R)
3. People with strong characters can get over mental health concerns by themselves and would have little need for professional help. (R)
4. People should work out their own problems; getting professional help should be a last resort. (R)
5. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns. (R)
6. There is something admirable in the attitudes of people who are willing to cope with their conflicts and fears without resorting to professional help. (R)
7. There are experiences in my life I would not discuss with anyone. (R)
8. It is probably best not to know everything about oneself. (R)

Help-seeking propensity:

9. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.
10. I would want to get professional help if I were worried or upset for a long period of time.
11. If I were experiencing a mental health concern at this point in my life, I would be confident that I could find relief in psychotherapy.
12. It would be relatively easy for me to find the time to see a professional for mental health concerns.
13. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for mental health concerns.
14. If I were to experience mental health concerns, I could get professional help if I wanted to.
15. If good friends asked my advice about a mental health concern, I might recommend that they see a professional.
16. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

Indifference to Stigma:

17. Being mentally ill carries with it a burden of shame. (R)
18. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems. (R)
19. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems. (R)
20. Being diagnosed with a mental disorder is a blemish on a person's life. (R)
21. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it. (R)
22. I would feel uneasy going to a professional because of what some people would think. (R)
23. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems. (R)
24. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."

Scoring

(R) indicates items that will be reverse coded. After appropriate item(s) are reverse coded, the mean score will be calculated for each subscale and a mean composite score will be calculated for the scale overall. Higher subscale scores will indicate: greater psychological openness, greater help-seeking propensity, and less indifference to stigma. Higher composite scores will indicate more positive attitudes toward clinical help seeking.

**Non-clinical Help-Seeking (Eisenberg et al., 2009)**
*Instructions: Please respond to the questions below. There are no right or wrong answers. We are interested in the responses that are most true to how you really feel.*

1. If you were experiencing a mental health concern, from who would you seek counseling or support? Please check all that apply.
    a. Friend
    b. Family member
    c. Romantic partner
    d. Religious counselor or other religious or spiritual contact
    e. Support group (online or face-to-face)
    f. Another non-clinical source (please specify) ____
    g. No one

2. If you/your child had a mental health problem that was affecting your/his or her academic performance, which people at school would you talk to/suggest your child talk to? Please check all that apply.
    a. Professor from a class
    b. Academic advisor
    c. Another faculty member
    d. Teaching assistant
    e. Student services staff
    f. Dean of Students or Class Dean
    g. Other (please specify) _____
    h. No one

Scoring
Frequencies will be reported.

**Child-Parent Communication Apprehension (adapted from Lucchetti, Powers, & Love, 2002)**

*Instructions: Once again, thinking about the mental health-related portions of the conversation you just had, please respond to each of the following items by using the options below. There are no right or wrong answers here. People may feel a variety of ways when talking with family members about mental health.*

Strongly Disagree 1 2 3 4 5 Strongly Agree

1. I felt relaxed when talking with my parent/child about mental health today. (R)
2. I had no fear or hesitation in discussing mental health with my parent/child. (R)
3. I was comfortable developing an intimate conversation about mental health with my parent/child.
4. I was looking forward to talking about mental health with my parent/child. (R)
5. During this conversation with my parent/child about mental health, I didn't feel like I had to guard what I said. (R)
6. I was afraid to come right out and tell my parent/child exactly what I meant during our conversation about mental health.
7. I was so relaxed with my parent/child that I could really be an open communicator with him or her during our conversation about mental health. (R)
8. I was tense about developing an in-depth conversation about mental health with my parent/child.
9. I felt strained when anticipating this talk about mental health with my parent/child.
10. During this conversation with my parent/child about mental health, I felt anxious and like I had to guard what I said.
11. I had no fear telling my parent/child exactly how I felt about the topics that came up during our conversation about mental health. (R)
12. I had no anxiety about telling my parent/child my needs during our conversation about mental health. (R)

Scoring
(R) indicates items that will be reverse coded. A mean score will be calculated such that higher scores will indicate greater communication apprehension.

**Relational Distancing (Vangelisti & Young, 2000)**

*Instructions: Still keeping in mind the mental health-related parts of the discussion you just had, please use the words below to describe the conversation with your parent/child by selecting the appropriate space. For example, if you think that the health-related parts of the conversation brought you and your parent/child a lot closer, select the space right next to "close." If you think those portions of the conversation made you much more distant, select the space right next to "distant."*

The conversation made us more:_____

distant : ____ ____ ____ ____ ____ ____ ____ : close (R)

relaxed : ____ ____ ____ ____ ____ ____ ____ : tense

hostile : ____ ____ ____ ____ ____ ____ ____ : friendly (R)

intimate : ____ ____ ____ ____ ____ ____ ____ : remote

closed : ____ ____ ____ ____ ____ ____ ____ : open (R)

Scoring

(R) indicates items that will be reverse coded. The spaces will be converted to numbers, beginning with "1" for the most left-hand space and ending with "7" for the most right-hand space. The mean score will be calculated such that higher scores will indicate greater relational distancing.

**Stigma Orientation Measure (Day, Edgren, & Eshleman, 2007)**
*Instructions: Please indicate the extent to which you agree or disagree with the statements listed below. There are no right or wrong answers.*

Completely Disagree 1 2 3 4 5 6 7 Completely Agree

1. People with mental illnesses tend to neglect their appearance. (Hygiene)
2. It would be difficult to have a close meaningful relationship with someone with a mental illness. (Relationship Disruption)
3. I probably wouldn't know that someone has a mental illness unless I was told. (Visibility; R)
4. There is little that can be done to control the symptoms of mental illness. (Treatability)
5. People with mental illnesses will remain ill for the rest of their lives. (Recovery)
6. I feel nervous and uneasy when I'm near someone with a mental illness. (Anxiety)
7. Mental health professionals, such as psychiatrists and psychologists, can provide effective treatments for mental illnesses. (Professional Efficacy; R)

Scoring
(R) indicates items that will be reverse coded. An overall mean score will be calculated. Higher scores will indicate greater stigma toward mental illness.

**Conversational Experience Measure (Hines et al, 2001; Scott, 2010)**
*Instructions: We'd like to know about your experience talking about mental health and mental illness. Please let us know about any discussions you've had that were like the one you just had with your parent/child.*

1. Before your conversation today, about how many conversations about **mental health** have you had with the parent/child you spoke with today? Please write the approximate number of conversations you've had here: _____

2. Before your conversation today, about how many conversations about **mental illness** have you had with the parent/child you spoke with today? Please write the approximate number of conversations you've had here: _____

3. Now think about how many conversations about mental health or mental illness you've had with any other family member (not including the parent/child you spoke with today). Please tell us your relationship with the person(s) (for example, "husband" or "daughter") and the approximate number of times you've talked with each family member:

a. Person's relationship to me _____Number of conversations: _____
b. Person's relationship to me _____Number of conversations: _____
c. Person's relationship to me _____Number of conversations: _____
d. Person's relationship to me _____Number of conversations: _____
e. Person's relationship to me _____Number of conversations: _____
f. Person's relationship to me _____Number of conversations: _____

4. Finally about how many conversations about mental health or mental illness have you had with any of your doctors? Please write the approximate number of conversations here: _____

Scoring
Frequencies and descriptive statistics will be reported.

**Previous Clinical and Non-Clinical Help-Seeking Experience Measure (Adapted from Rickwood, Deane, Wilson, & Ciarrochi, 2005; Wells, Sturm, & Burnam, 2004).**

*Instructions: We'd like to know about your personal experience seeking clinical and non-clinical help for mental illness. Mental illness encompasses a wide range of health conditions involving changes in thinking, emotion, or behavior and is associated with distress and problems functioning at school, work, with friends, or with family. For example, depression, anxiety, post-traumatic stress disorder, disordered eating, and bipolar disorder are considered mental illnesses.* ***Please indicate if you have sought help for a mental illness from any of the following sources <u>in the past 12 months</u>****.*

1. The parent/child you spoke with today _____
2. Spouse or romantic partner ____
3. Child ____
4. Mother ____
5. Father ____
6. Sibling ____
7. Friend ____
8. Classmate____
9. Colleague ____
10. Supervisor ____
11. Instructor or professor ____
12. Religious or spiritual advisor ____
13. Coach ____
14. Online support group____
15. Offline support group ____
16. Telephone help line ____
17. Physical-health doctor/general practitioner ____
18. Therapist ____
19. Counselor ____
20. Psychologist ____
21. Psychiatrist ____
22. Other (please specify) ____

Scoring: Frequencies and descriptive statistics will be reported. If used as a control variable, responses indicating that help was sought from a source will be coded as 1 and non-responses or blank responses indicating that help was NOT sought from a source will be coded as 0.

## APPENDIX E

Demographic Items

*Instructions: Please respond to the following questions. As a reminder, mental illness encompasses a wide range of health conditions involving changes in thinking, emotion, or behavior and is associated with distress and problems functioning at school, work, with friends, or with family. Examples of mental illness include depression, anxiety, post-traumatic stress disorder, disordered eating, and bipolar disorder.*

1. Please indicate your age: _____

2. Please indicate your race/ethnicity:

    a. White
    b. Black or African American
    c. American Indian or Alaska Native
    d. Hispanic or Latino/a
    e. Asian or Asian American
    f. Native Hawaiian or Pacific Islander
    g. Other (please specify)

3. Please indicate your sex:
    a. Male
    b. Female
    c. Nonbinary
    d. Other (please specify)

4. Have you personally experienced a mental illness?
    a. Yes
    b. No

5. [IF YES TO #4] Do you currently have a mental illness diagnosis?
    a. Yes (please specify)
    b. No

6. [IF YES TO #4] Are you currently managing or receiving treatment for a mental illness (for example, counseling, therapy, medication, etc.)?
    a. Yes (please specify)
    b. No

7. Has a friend, family member, or close other experienced a mental illness?
    a. Yes
    b. No

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